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ABNORMAL PSYCHOLOGY

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UNIT -1

INTRODUCTION AND THEORITICAL PERSPECTAIVES OF ABNORMAL BEHAVIOUR

Structure

1.1 INTRODUCTION

You may witnessed a man with shabby and ugly look with lot of garages in his hand, talking and laughing to himself and roam around the place. You may wonder why he behaving like this? What happened to him? Is he normal? Then you come to the conclusion that he is abnormal. In this lesson, we explore the lives of people with troubling psychological symptoms to understand how they think, what they feel, and how they behave. We investigate what is known about the causes of these symptoms and the appropriate treatments for them. The psychology branch which deals with mental disorder is called as Abnormal Psychology. Abnormal psychology has implications for all of

us. Everyone has feelings, thoughts, and behaviors, and occasionally these become troublesome for us or for someone we know.

1.2 Objectives

After completion this unit, you will be able to understand the following concept

- Definition of abnormality
- Classification of mental disorder
- Causes for abnormal behavior

1.3 DEFINING ABNORMALITY

Abnormal psychology is the scientific study of troublesome feelings, thoughts, and behaviors associated with mental disorders. This area of science is designed to evaluate, understand, predict, and prevent mental disorders and help those who are in distress.

There is still no universal agreement about what is meant by *abnormality* or *disorder*. This is not to say we do not have definitions; we do. However, a truly satisfactory definition will probably why does the definition of a mental disorder present so many challenges? A major problem is that there is no one behavior that makes someone abnormal. However, there no single indicator is sufficient to define or determine abnormality. Nonetheless, the more that someone has difficulties in the following

1. *Suffering:* If people suffer or experience psychological pain we are inclined to consider this as indicative of abnormality. Depressed people clearly suffer, as do people with anxiety disorders.

2. *Maladaptiveness:* Maladaptive behavior is often an indicator of abnormality. The person with depression may withdraw from friends and family and may be unable to work for weeks or months. Maladaptive behavior interferes with our wellbeing and with our ability to enjoy our work and our relationships. However, not all disorders involve maladaptive behavior

3. ***Statistical Deviancy:*** The word *abnormal* literally means "away from the normal." But simply considering statistically rare behavior to be abnormal does not provide us with a solution to our problem of defining abnormality. Genius is statistically rare, as is perfect pitch. However, we do not consider people with such uncommon talents to be abnormal in any way. Also, just because something is statistically common

4. ***Violation of the Standards of Society:*** All cultures have rules. Some of these are formalized as laws. Others form the norms and moral standards that we are taught to follow. Although many social rules are arbitrary to some extent, when people fail to follow the conventional social and moral rules of their cultural group we may consider their behavior abnormal. For example, wearing bikhini is considered abnormal in India but it is very common in Europe.

5. ***Social Discomfort:*** When someone violates a social rule, those around him or her may experience a sense of discomfort or unease. how do you feel when someone you met only 4 minutes ago begins to chat about her suicide attempt? Unless you are a therapist you would probably consider this an example of abnormal behavior.

6. ***Irrationality and Unpredictability:*** we expect people to behave in certain ways. Although a little unconventionality may add some spice to life, there is a point at which we are likely to consider a given unorthodox behavior abnormal. If a person sitting next to you suddenly began to scream and yell obscenities at nothing, you would probably regard that behavior as abnormal.

One final point bears repeating. Decisions about abnormal behavior always involve social judgments and are based on the values and expectations of society at large. This means that culture plays a role in determining what is and is not abnormal

The *DSM-5* Definition of Mental Disorder

Behavioral or psychological syndrome (or pattern) that is present in an individual and that reflects some kind of underlying psychobiological dysfunction. Importantly, this behavioral syndrome should result in clinically significant distress, disability, or impairment in key areas of functioning. Predictable responses to common stressors or losses (such as death of a loved one) are excluded. It is also important that this dysfunctional pattern of behavior not stem from social deviance or conflicts that the person has with society as a whole.

Why Do We Need to Classify Mental Disorders?

At the most fundamental level, classification systems provide us with a **nomenclature** (a naming system) and enable us to structure information in a more helpful manner. Organizing information within a classification system also allows us to study the different disorders that we classify and therefore to learn more not only about what causes them but also how they might best be treated. For this reason, APA and ICD are used in psychology.

1.4 Classification systems

A classification system for abnormal behaviors aims to provide distinct categories and indicators for atypical behaviors, thought processes, and emotional disturbances. Psychiatric classification systems are like a catalog: a detailed description accompanies each mental disorder. Thus, the pattern of behavior associated with each diagnosis is distinctly different. For example, the symptoms associated
Today, there are two major psychiatric classification systems in use: the *International Classification of Disease* (ICD-10) system, published by the World Health Organization, and the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), published by the American Psychiatric Association. The ICD-10 system is widely used in Europe and many other countries, whereas the *DSM* system is the standard guide for the United States.

The Diagnostic and Statistical Manual of Mental Disorders

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a widely used classification system for psychiatric disorders. The DSM lists all officially designated mental disorders and the characteristics or symptoms needed to confirm a diagnosis. Diagnostic criteria include physical, behavioral, and emotional characteristics associated with a disorder. For all disorders, the symptoms must cause significant distress or impairment in social, occupational, or other important areas of functioning. The DSM is widely used in the United States, another important classification system is the International Classification of Disease (ICD). This system covers all health conditions, including mental disorders. The World Health Organization oversees the system.

All of the DSMs are based on the classification system Emil Kraepelin developed around 1850. Kraepelin believed that mental disorders were like physical disorders, each with a specific set of symptoms. To add to the complexity, the number of identified psychological disorders has increased dramatically over time DSM,

DSM-I, 1952: 106 mental disorders
DSM-II, 1968: 182 mental disorders
DSM-III, 1980: 265 mental disorders
DSM-III-R: 292 mental disorders
DSM-IV, 1994: 297 mental disorders

DSM-5, published in May 2013, did not significantly increase the number of diagnostic categories, although some new disorders were added.

Check your progress

1. What is Abnormal Psychology?
2. What is DSM?

1.5 Causes and Risk Factors for Abnormal Behavior

Central to the field of abnormal psychology are questions about what causes people to experience mental distress and to behave maladaptive. If we knew the causes for given disorders, we might be able to prevent conditions that lead to them and perhaps reverse those

that maintain them. We could also classify and diagnose disorders better if we clearly understood their causes rather than relying on clusters of symptoms. Although understanding the causes of abnormal behavior is clearly a desirable goal, it is enormously difficult to achieve because human behavior is so complex.

Necessary, Sufficient, and Contributory Causes

Regardless of one's theoretical perspective, several terms can be used to specify the role a factor plays in the **etiology**, or causal pattern, of abnormal behavior. A **necessary cause** (e.g., cause X) is a condition that must exist for a disorder (e.g., disorder Y) to occur. For example, general paresis (Y)—a degenerative brain disorder—cannot develop unless a person has previously contracted syphilis (X)

A **sufficient cause** (e.g., cause X) of a disorder is a condition that guarantees the occurrence of a disorder (e.g., disorder Y). For example, one current theory hypothesizes that hopelessness (X) is a sufficient cause of depression (Y).

A contributory cause (e.g., cause X) is one that increases the probability of a disorder (e.g., disorder Y) developing but is neither necessary nor sufficient for the disorder to occur. Or, more generally, if X occurs, then the probability of occurring Y increases. For example, parental rejection could increase the probability that a child will later have difficulty in handling close personal relationships or could increase the probability that being rejected in a relationship in adulthood will precipitate depression.

Necessary Cause If Disorder Y occurs, then Cause X must have preceded it.

Sufficient Cause If Cause X occurs, then Disorder Y will also occur.

Contributory Cause If X occurs, then the probability of Disorder Y increases.

A *reinforcing contributory cause* is a condition that tends to maintain maladaptive behavior that is already occurring. An example is the extra attention, sympathy, and relief from unwanted responsibility that may come when a person is ill; these pleasant experiences may unintentionally discourage recovery

1.5.1 BIOLOGICAL FACTORS

We will focus here on four categories of biological factors that seem particularly relevant to the development of maladaptive behavior: (1) neurotransmitter and hormonal abnormalities in the brain or other parts of the central nervous system, (2) genetic vulnerabilities, (3) temperament, and (4) brain dysfunction and neural plasticity. Each of these categories encompasses a number of conditions that influence the quality and functioning of our bodies and our behavior.

Imbalances of Neurotransmitters and Hormones

The imbalances in neurotransmitters in the brain can result in abnormal behavior. There may be excessive production and release of the neurotransmitter substance into the synapses, causing a functional excess in levels of that neurotransmitter Hormones are chemical messengers secreted by a set of endocrine glands in our bodies. Each of the endocrine glands produces and releases its own set of hormones.

Genetic Vulnerabilities

Genes are the carriers of genetic information that we inherit from our parents and other ancestors, and each gene exists in two or more alternate forms called *alleles*. Although neither behavior nor mental disorders are ever determined exclusively by genes, there is substantial evidence that most mental disorders show at least some genetic influence ranging from small to large genes can affect behavior only indirectly. Gene “expression” is normally not a simple outcome of the information encoded in DNA but is, rather, the end product of an intricate process that may be influenced by the internal (e.g., intrauterine) and external environment.

Temperament

Temperament refers to a child's reactivity and characteristic ways of self-regulation. Our early temperament is thought to be the basis from which our personality develops the temperament of an infant or young child has profound effects on a variety of important developmental processes (Fox et al., 2010; Rothbart et al., 2000). For example, a child with a fearful temperament learns to fear social situations.

Brain Dysfunction and Neural Plasticity

Brain lesions with observable defects in brain tissue are rarely a primary cause of psychiatric disorders. *neural plasticity*—flexibility of the brain in making changes in organization and function in response to pre- and postnatal experiences, stress, diet, disease, drugs, maturation, and so forth. Existing neural circuits can be modified, or new neural circuits can be generated (e.g., Fox et al., 2010; Kolb et al., 2003). The effects can be either beneficial or detrimental to the individual, depending on the circumstances.

Check your progress

3. What is temperament? 4. What is neural plasticity?

1.5.2 PSYCHOLOGICAL CAUSAL FACTORS

Psychological factors make people vulnerable to disorder or that may precipitate the disorder. Psychological factors are those developmental influences—often unpredictable and uncontrollable negative events—that may handicap a person psychologically, making him or her less resourceful in coping with events. Four categories of psychological causal factors that can each have important detrimental effects on a child's socio emotional development: (1) early deprivation or trauma, (2) inadequate parenting styles, (3) marital discord and divorce, and (4) maladaptive peer.

Early Deprivation or Trauma

Children who do not have the resources that are typically supplied by parents or parental surrogates may be left with deep and sometimes

irreversible psychological scars. The resources range from food and shelter to love and attention. Deprivation of such resources can occur in several forms. The most severe manifestations of deprivation are usually seen among abandoned or orphaned child relationships the consequences of parental deprivation from several psychological viewpoints. Such deprivation might result in fixation at the oral stage of psychosexual development (Freud); it might interfere with the development of basic trust (Erikson); it might retard the attainment of needed skills because of a lack of available reinforcements (Skinner); or it might result in the child's acquiring dysfunctional schemas and self-schemas in which relationships are represented as unstable, untrustworthy, and without affection (Beck).

Neglect and abuse in the home

Parents can neglect a child in various ways—by physical neglect, denial of love and affection, lack of interest in the child's activities and achievements, or failure to spend time with the child or to supervise his or her activities Outright parental abuse (physical or sexual or both) of children has been associated with many negative effects on their emotional, intellectual, and physical development.

Separation

Children who undergo a number of such separations may develop an insecure attachment. In addition, there can be longer-term effects of early separation from one or both parents. For example, such separations can cause an increased vulnerability to stressors in adulthood.

Inadequate Parenting Styles

Inadequate parenting styles can have profound effects on a child's subsequent ability to cope with life's challenges and thus create vulnerability to various forms of psychopathology.

Parental psychopathology

It has been found that parents who have various forms of psychopathology (including schizophrenia, depression, antisocial personality disorder, and alcohol abuse or dependence) tend to have one

or more children who are at heightened risk for a wide range of developmental difficulties.

MARITAL DISCORD

Marital discord is likely to be frustrating, hurtful, and generally damaging in its effects on both adults and their children. Divorce can have traumatic effects on children, too. Feelings of insecurity and rejection may be aggravated by conflicting loyalties and sometimes, by the spoiling the children may receive while staying with one of the parents. Not surprisingly, some children do develop serious maladaptive responses.

1.5.3 SOCIOCULTURAL CAUSAL FACTORS

There are many sources of pathogenic social influences. Some of these stem from socioeconomic factors. Others stem from socio-cultural factors regarding role expectations and from the destructive forces of prejudice and discrimination.

Low Socioeconomic Status and Unemployment

The higher incidence of mental and physical disorders reported in lower socio economic class. The strength of this inverse correlation varies with different types of mental disorder, however. For example, antisocial personality disorder is strongly related to socioeconomic status (SES).

Prejudice and Discrimination in Race, Gender, and Ethnicity

Discrimination may serve as a stressor that threatens self-esteem, which in turn increases psychological distress (e.g., Cassidy et al., 2004). A recent study of Arab and Muslim Americans two years after the bombing of the World Trade Center in New York found increased psychological distress, lower levels of happiness, and increased health problems in those who had experienced personal or familial prejudice, discrimination, or violence since the World Trade Center disaster.

1.6 Let's Sum Up

Abnormal psychology is the study of the symptoms and causes of behavioral and mental disorders; the objectives are to describe, explain, predict, and modify distressing emotions and behaviors. Four criteria are

used to determine and define abnormality: distress, deviance, dysfunction, and dangerous. Cultural context and sociopolitical factors can influence definitions of abnormality. Criteria used to define normality or abnormality must be considered in light of community standards, changes over time, cultural values, and sociopolitical experience. Over the course of a year, approximately 25 percent of adults in the United States experience a mental disorder.

1.7 Unit End Exercise

1. How do we differentiate between normal and abnormal behaviors?
2. What societal factors affect definitions of abnormality?
3. What were early explanations regarding the causes of mental disorders?
4. What are some contemporary trends in abnormal psychology?

1.8Answers for check your progress

1. Abnormal psychology is the scientific study of troublesome feelings, thoughts, and behaviors associated with mental disorders.
2. DSM means Diagnostic statistical manual for mental disorder
3. Temperament refers to a child's reactivity and characteristic ways of self-regulation.
4. Neural plasticity—flexibility of the brain in making changes in organization and function in response to pre- and postnatal experiences, stress, diet, disease, drugs, maturation, and so forth.

1.9 Suggested Readings

1. Davidson and Neal (1996). Abnormal psychology. Revised 6th Edition, John Wiley sons

2. World Health Organization. (2008). ICD-10: International statistical classification of diseases and related health problem (10th Rev. ed.). New York: Author.

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Unit 2

NORMALITY & ABNORMALITY

Structure

2.1 Introduction
2.2 Objectives
2.3 Concept of normality
2.4 Mental health
2.5 Jahoda's positive mental health
2.6 Gordon Allport mature personality
2.7 Defining abnormality
2.8 Let's sum up
2.9 Unit End Exercise
2.10 Answers for check your progress
2.11 Suggested Readings

2.1 Introduction

Sometimes it's fairly easy to identify behavior as abnormal, as when someone is still deeply troubled by events that happened 40 years ago or is feeling so hopeless that he or she cannot get out of bed. But sometimes identifying behavior as abnormal is not clear-cut. Put simply, *abnormal* means "away from normal," but that is a circular definition. By this standard, normal becomes the statistical average and any deviation becomes "abnormal." For example, if the average weight for a woman living in India is 60 kgs, then women who weigh less than 40 kgs or more than 90 kgs deviate significantly from the average. Their weight would be considered abnormally low or high. For abnormal psychology, defining abnormal behavior as merely being away from normal assumes that deviations on both sides of average are negative and in need of alteration or intervention. This assumption is often incorrect. Specifically, we must first ask whether simply being different is abnormal.

2.2 Objectives

After studying this unit you will be able to understand the following concept

- Normality
- Abnormality
- Jahoda's Positive mental health
- Allport mature personality

2.3 CONCEPT OF NORMALITY

The concept of normal is not an uncontroversial topic in psychiatry. When one gives a patient diagnosis, one is describing abnormal psychology or psychopathology and it implies that there is the concept of normal. Hawker (2008), states that normal means standard, usual, ordinary, conventional, expected, typical, common, regular, unremarkable, of sound mind and compos mentis. Professor Nicholas Dent, (Honderich, 1995), describes normative as the, "average or usual level of attainment or performance for an individual or a group, or … (as) a standard rule, principle used to judge or direct human conduct as something to be complied with".

Normal here is unimpaired mental functioning. The problem with average mental functioning is that the very high IQ is something that most people would regard as very desirable, is not average or normal. Normal is therefore not always a desirable state.

Sigmund Freud and the Normal/Abnormal:

Freud (1901), points out that, "normal forgetting takes place by way of condensation". There's no evidence for this. Later in 1905, Freud states that, "a periodic oscillation between a normal and an inverted sexual object has also sometimes been observed. Those cases are of particular interest in which the libido changes over to an inverted sexual object after a distressing experience with a normal one". Later in 1907, Freud pointed out that, "The fact is that we must put sexual

repression as an internal factor alongside such external factors as limitation of freedom, inaccessibility of a normal sexual object, the dangers of the normal sexual act, etc., which bring about perversions in persons who might perhaps otherwise have remained normal", and that, "inversions [can] found in people who exhibit no other serious deviations from the norm".

In discussing normal, the major difficulty comes between normality and people with mild abnormalities. Moderate and severe abnormalities are real enough. It's on the borderline between normal and mild where the major difficulties occur and still occur in psychiatry. This boundary is and is likely to remain blurred. Psychiatry has seriously lowered the diagnostic threshold, and this is where so many of its current problems have come from. Another definition of a person whose normal mentally would be a person who doesn't need to see a psychiatrist but that begs the question and is not suffering abnormal levels of psychological pain, or causing pain to his family or society.

Check your Progress

1. What is Normality?

2.4 MENTAL HEALTH

Mental health can affect daily living, relationships and physical health. Looking after mental health can preserve a person's ability to enjoy life. Doing this involves reaching a balance between life activities, responsibilities, and efforts to achieve psychological resilience. Conditions such as stress, depression, and anxiety can all affect mental health and disrupt a person's routine. Although the term mental health is in common use, many conditions that doctors recognize as psychological disorders have physical roots.

According to the World Health Organization (WHO):

“Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community.”

The WHO stress that mental health is “more than just the absence of mental disorders or disabilities.” Peak mental health is about not only avoiding active conditions but also looking after ongoing wellness and happiness. They also emphasize that preserving and restoring mental health is crucial on an individual basis, as well as throughout different communities and societies the world over. In 2017, an estimated 11.2 million adults in India, or about 4.5% of adults, had a severe psychological condition, according to the National Institute of Mental Health (NIMH).

Check your Progress

2. What is mental health?

2.5 JAHODA’S POSITIVE MENTAL HEALTH

Marie jahoda published a book on 1985. This book is used for the study & a great source for defining characteristics of mental health. Jahoda wants her discussion to lead first to description of various type of human behaviors called mentally healthy. When discussing criteria of healthy Jahoda starts by dismissing three common suggestions of sufficient & necessary criteria of positive mental health.(1)the absence of disease (2)statistical normality (3)well being.

Jahoda argues that we can’t define the mental health as the absence of mental disease. She gives three reasons for this.

First, it is not possible to find physiological causes for mental disease. Second: there are cultural differences as to what to be considered mental disease. However there are people who have tried to give universal criteria for mental disease.

In psychoanalytic theory, disease is seen as the expression of conflicts in unconscious and it is debatable. Jahoda concludes defining the positive mental health as the absence of mental disease is for this reason difficult. The Third reason Jahoda finds that there is no continuing between health and disease. One indicator of this is that we sometimes talk about diseased person as having health. Jahoda concludes the opposite view that the absence of disease might after all, be necessary requirement for health.

The First reason Jahoda suggested about the positive attitude towards the self as individual feels happy with themselves

The Second reason Jahoda suggested about the autonomy states about having the independence & self- reliance, that is not depending on others.

The Third reason Jahoda suggested about the environmental mastery. A person can adopt to any new situation & feels free is all position of life.

The fourth reason Jahoda suggested about the resistance to stress. In any stressed situation the person can handle the situation completely.

The Fifth reason Jahoda suggested about the accurate perception of reality. The situation is how the individual sees the world around them

The sixth reason Jahoda suggested about the self- actualization. The situation you feels that you have become the best you can be in a state of contentment. Jahoda stated that the individual should experience

all these optimum mental health and if someone not fulfilled, the person will experience difficulties.

2.6 GORDON ALLPORT'S; THE MATURE PERSON

Allport believed healthy individuals function on a rational and conscious level, aware and in control of the forces that guide them. Allport only studied mature, healthy adults and had little to say about neurotics, hence, his system is truly health oriented. In fact he believed the healthy person's life could be grim with pain and sorrow. To this end, Allport (1955) wrote: "Salvation comes only to him who ceaselessly bestirs himself in the pursuit of objectives that in the end are not fully attained.

Allport's theory of motivation of the healthy personality also includes the principle of mastery and competence which proposes that mature. The woman whose goal was to raise children must find new goals and redirect energy once the children reach adulthood.

CRITERIA FOR MATURE PERSONALITY

The following seven criteria of maturity represent Allport's characteristics of healthy personality.

Extension of the Sense of Self

Allport believed that the person needed to extend the self into activities with a feeling of genuine personal involvement and participation. This sense of authentic participation applies to work, family, leisure and all aspects of living .i.e. an individual is fully involved with various activities, people, or ideas, the more psychologically healthy he or she will be.

Warm Relating of Self to Others

Allport reported two kinds of warmth in relation to other people: the capacity for intimacy and the capacity for compassion. The healthy person can display intimacy (love) for a parent child, spouse, or close friend. The second kind of warmth, relates to an understanding of the basic human condition and a sense of kinship with all people. Empathy for others results from an "imaginative extension" of one's own feelings to humanity.

Emotional Security

This characteristic of healthy personality includes (1) self-acceptance(2) frustration tolerance and (3)emotional control.

(1)Self-acceptance is the most important and involves accepting all aspects of one's being, including weaknesses and failings, without being resigned to them.

(2)Frustration-tolerance relates to tolerating stress and the thwarting of wants and desires, Frustration is not crippling as it may be for neurotics.

(3)Emotional control pertains to an individual's control of personal emotions so they do not disrupt social functioning. The control is not repression, but a redirecting of the emotions into more constructive channels.

Realistic Perception

Healthy persons regard their world objectively and they accept reality for what it is.

Skills and Assignments

Work and responsibility provide meaning and a sense of continuity to life. Allport believed in the importance of work and the necessity of losing oneself in this activity. He did not think it possible to find mature, healthy persons who have not directed their skills toward their work.

Self-objectification

The individual who possesses a high level of self-objectification - meaning self-insight - achieves a higher level of self-understanding. Allport suggested that those with greater selfinsight are more intelligent than those who possess less selfinsight.

A Unifying Philosophy of Life

Values are vital to the development of a unifying philosophy of life. The neurotic's values are thought to not be strong enough to unify all aspects of life.

Check your Progress

3. What is Self acceptance?
4. What is emotional control?

2.7 A DEFINITION OF ABNORMAL BEHAVIOR

We define **abnormal behavior** as behavior that is inconsistent with the individual's developmental, cultural, and societal norms; creates emotional distress; or interferes with daily functioning.

Factors Influencing the Expression of Abnormal Behaviors

Contextual factors play an important role when considering if and when abnormal behaviors may develop. Some factors include personal characteristics such as sex and race or ethnicity. For example, women are more likely to suffer from anxiety disorders and mood disorders and men are more likely to suffer from alcohol and drug abuse. *Socioeconomic status* (SES), defined by family income and educational achievement, is another important factor that affects the prevalence of psychological disorders in the general population. Genetic vulnerabilities plays a crucial role in abnormal behavior.

2.8 Let's Sum Up

Being different, or behaving differently, does not necessarily mean that someone is suffering from a psychological disorder. Determining the presence of abnormal behavior requires evaluation of the behavior in terms of its developmental, cultural, and societal contexts. The current diagnostic system uses a categorical approach to classification of abnormal behavior. However, psychological symptoms rarely fall into one neat category. Furthermore, it is often difficult to determine the boundary between normal feelings such as sadness and psychological disorders such as depression. In these instances, a dimensional approach may be more useful. Today biological, psychological, socio cultural, and bio psychosocial explanations dominate the explanations for the development of abnormal behavior. Each of the etiological theories has strengths and weaknesses, and each alone is inadequate to fully explain the presence of abnormal behavior. Determining abnormal behavior is complex, and it is likely that a combination of factors is responsible for any specific psychological disorder. There are many competing theories, and as science progresses, new theories will be developed and others will be discarded.

2.9 Unit End Exercise

1. Describe Jahoda's positive mental health.
2. Explain Allport mature personality
3. What is abnormal Behavior?
4. Describe the factors that affect the prevalence of abnormal behavior?

2.10 Answers for check your progress

1. Normality means un-impairment mental functioning.

2. "Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community."

3. Self-acceptance is the most important and involves accepting all aspects of one's being, including weaknesses and failings, without being resigned to them.

4. Emotional control is not repression, but a redirecting of the emotions into more constructive channels.

2.11 Suggested Readings

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UNIT 3

WAYS OF THINKING ABOUT ABNORMAL BEHAVIOUR

Structure

3.1 INTRODUCTION

Abnormal behavior is sometimes difficult to define. It is not just behavior that is different because certain differences can sometimes be positive for the individual and perhaps for society. Behavior that is deviant may be different but not necessarily abnormal. New trends often start as deviant but then become accepted by mainstream society. Dangerous behavior may be abnormal, but many individuals who have

psychological disorders do not engage in dangerous behavior. Dangerous behavior is not necessary or sufficient to meet the definition of abnormal behavior. Two primary considerations for determining whether a behavior is abnormal is whether it creates dysfunction (interferes with daily activities) and /or emotional distress.

3.2 Objectives

After studying this unit, you should be able to understand the following concept

- Concept of abnormal behavior
- Multi models of abnormal behavior
- Clinical assessment and
- Classification

3.3 CONCEPTION OF ABNORMAL BEHAVIOUR

Historically, spirit possession was among the first proposed causes of abnormal behavior. However, as early as the classical Greek and Roman periods, biological and environmental explanations were given for some of the major psychiatric disorders (depression, schizophrenia). Such theories fell out of favor in Western Europe shortly afterward although they continued to flourish in the Middle East. It was not until the Renaissance period that theories based on biology and environmental factors re-emerged in Europe

Today, biological, psychological, sociocultural, and biopsychosocial explanations dominate the explanations for the development of abnormal behavior. Each of the etiological theories has strengths and weaknesses, and each alone is inadequate to fully explain the presence of abnormal behavior. Determining abnormal behavior is complex, and it is likely that a combination of factors is responsible for any specific psychological disorder. There are many competing theories, and as science progresses, new theories will be developed and others will be discarded.

3.4 MULTIDIMENSIONAL MODELS OF ABNORMAL BEHAVIOUR

In this chapter, we introduce some of the different models that try to explain abnormal behavior. You might wonder why so many different models exist. The answer is that abnormal behavior is very complex, and no one model appears capable of providing a comprehensive explanation. Using a scientific approach, researchers develop, examine, and discard models as new facts emerge. Next we examine some of the currently accepted models of abnormal behavior.

3.4.1 BIOLOGICAL MODELS

The biological model assumes that abnormal behavior results from biological processes of the body, particularly the brain. Technology breakthroughs such as computerized axial tomography (CAT) scans and magnetic resonance imaging (MRI) allow direct examination of brain structure and activity. With this direct observation, we now have a much greater understanding of the role of the brain in abnormal behavior. Imaging tests such as the CAT scan and MRI examine the *morphology* (structure) of the brain and are used to determine whether parts of the brain are structurally different in those with and without psychological disorders. Post-traumatic stress disorder (PTSD, an anxiety disorder some abnormal behaviors may be related to structural abnormalities, that occurs after a traumatic event), changes in the brain appears. Studies of brain *functioning* appear to be a more promising avenue of research. Advanced neuro imaging techniques such as positron emission tomography (PET) and functional magnetic resonance imaging allow for mapping various areas of the brain and identifying brain areas that might be associated with various disorders.

GENETIC VULNERABILITIES

The field of **behavioral genetics** emerged with works by Sir Francis Galton (1822–1911) and his 1869 publication, *Hereditary*

Genius. Since that time, behavioral genetics has explored the role of both genes and environment in the transmission of behavioral traits

Viral Infection theory

Specifically, during the prenatal period or shortly after birth, viral infections might cause brain abnormalities that later lead to behavioral abnormalities. However, we cannot yet say that this is a definitive cause, for the results of one study sometimes directly contradict those of another.

3.4.2 PSYCHOLOGICAL MODELS

The biological model seeks the causes of abnormal behavior in the workings of the brain or body. In contrast, psychological approaches emphasize how environmental factors including parents and culture may influence the development and maintenance of abnormal behavior.

Modern Psychoanalytic Models:

Modern psychoanalysts propose that mental representations (views) of the self and others guide our interactions and may lead to psychological symptoms. Finally, they believe that personality development involves not only learning to regulate sexual and aggressive feelings but also having mature interpersonal relationships with others.

Behavioral Models

Learning theory stresses the importance of external events in the onset of abnormal behaviors. According to learning theory, *behavior* is the product of an individual's learning history. Abnormal behavior is therefore the result of maladaptive learning experiences. Behavioral theories do not ignore biological factors; instead, they acknowledge that biology interacts with the environment to influence behavior. Strict behaviorists focus on observable and measurable behavior and do not examine inner psychic causes.

Behavior therapists focus therapy on the elimination of abnormal behaviors and on the acquisition of new behaviors and skills. Treatment targets the patient's current symptoms

The Cognitive Model

The cognitive model proposes that abnormal behavior is are sult of distorted cognitive (mental) processes, not internal forces or external events. To change abnormal behaviors, cognitive therapy is directed at modifying the distorted thought processes do not affect our emotions and behavior; rather, the way we perceive or think about those events does. Imagine that you fail the first test in your abnormal psychology class. If you think to yourself, "Well, that was a hard test, but now I know what the instructor wants and I'll do better the next time," you are likely to feel okay

The Humanistic Model

Based on phenomenology, a school of thought that holds that one's subjective perception of the world is more important than the actual world, humanists believe that people are basically good and are motivated to *self-actualize* (develop their full potential). Abnormal behaviors occur when there is a failure in the process of self-actualization, usually as a result of people's failure to recognize their weaknesses and establish processes and strategies to fulfill their potential for positive growth.

3.4.3 SOCIOCULTURAL MODELS

All of the models of abnormal behavior discussed so far begin with the assumption that abnormality lies within the individual. Instead, **socio-cultural models** propose that abnormal behavior must be understood within the context of social and cultural forces, such as gender roles, social class, and interpersonal resources. From this perspective, abnormal behavior does not simply result from biological or psychological factors but also reflects the social and cultural environment in which a person lives.

3.4.4 THE BIOPSYCHOSOCIAL MODEL

Currently, most mental health clinicians subscribe to a **bio psychosocial perspective**, which acknowledges that many different factors probably contribute to the development of abnormal behavior and that different factors may be important for different people. The presence of a biological or psychological predisposition to a disease or disorder is called a *diathesis*. Rather, the predisposition is assumed to lie dormant (as if it does not exist) until stressful environmental factors create significant distress for the individual. People react differently to stressful events. The combination of a biological predisposition and the presence of environmental stress create psychological disorders. Modern scientists now recognize that (a) abnormal behavior is complex, (b) abnormal behavior cannot be understood using a single theoretical explanation, and (c) understanding abnormal behavior will advance only if we embrace and integrate the various conceptual models.

Check your progress

1. What is cat?
2. According to learning theory, what is abnormal behavior?

3.5 Clinical Assessment

The clinical assessment of any psychological problem involves a series of steps designed to gather information (or *data*) about a person and his or her environment in order to make decisions about the nature, status, and treatment of psychological problems. Typically, clinical assessment begins with a set of *referral questions* developed in response to a request for help. Usually, the request comes from the patient or someone closely connected to that person, such as a family member, teacher, or other health care professional.

3.6 GOALS OF ASSESSMENT

As part of the assessment process, the psychologist decides which procedures and instruments to administer. The patient's age, medical condition, and description of his or her symptoms strongly influence the tools selected for assessment, but the psychologist's theoretical perspective also affects the scope of the assessment.
Once an assessment has been completed and all data have been collected, the psychologist integrates the findings the process of assessment sometimes has a therapeutic effect. Assessment can be useful even before a referral is provided through the process of *screening*. Screenings can help identify people who have problems but who may not be aware of them or may be reluctant to mention them and/or those who may need further evaluation.

3.7 PROPERTIES OF ASSESSMENT INSTRUMENTS

The potential value of an assessment instrument rests in part on its various *psychometric properties*, which affect how confident we can be in the testing results.

Standadization

Standard ways of evaluating scores can involve normative or self-referent comparisons (or both).

Normative comparisons require comparing a person's score with the scores of a sample of people who are representative of the entire population (with regard to characteristics such as age, sex, ethnicity, education, and geographic region) or with the scores of a subgroup who are similar to the patient being assessed.

Self-referent comparisons are those that equate responses on various instruments with the patient's own prior performance, and they are used most often to examine the course of symptoms over time

Reliability The **reliability** of an instrument is its consistency, or how well the measure produces the same result each time it is give Reliability is assessed in many ways.

Validity A measure must not only be reliable but also valid. **Validity** refers to the degree to which a test measures what it was intended to assess. The instrument's validity tells us how well we are assessing these complicated dimensions

DEVELOPMENTAL AND CULTURAL CONSIDERATIONS

The assessment process itself may also vary depending on the patient's age. For example, different people may be involved in the assessment process if the patient is a child, an adult, or an elderly person with dementia. The assessment process should also consider cultural factors.

ETHICS AND RESPONSIBILITY

Psychologists must only use instruments that have good reliability and validity and are appropriate for the purpose of the examination. For example, it would be unethical for a psychologist to give a test if (a) he or she had not been trained to give the test, (b) the test had poor reliability and validity, or (c) the test people need to be aware of confidentiality limits before the assessment begins. Testing data should remain confidential and be stored in a secure location, even assessments that occur via the Internet.

3.8 ASSESSMENT INSTRUMENTS

Psychologists can select from a wide range of assessment instruments when planning an evaluation. Choosing the best set of instruments depends on the goals of the assessment, the properties of the instruments, and the nature of the patient's difficulties. Some instruments ask patients to evaluate their own. symptoms (*self-report measures*); others require a clinician to rate the symptoms (*clinician rated measures*). Some instruments assess *subjective responses* (what the patient perceives) and others *objective responses* (what can be

observed). Some measures are *structured* (each patient receives the same set of questions), and others are *unstructured* (the questions vary across patients)

3.8.1 CLINICAL INTERVIEWS

Clinical interviews consist of a conversation between an interviewer and a patient, the purpose of which is to gather information and make judgments related to the assessment goals. They also can be conducted in either an unstructured or structured fashion. In an **unstructured interview**, the clinician decides what questions to ask and how to ask them. Typically, the *initial interview* is unstructured. In a **structured interview**, the clinician asks each patient the same standard set of questions, usually with the goal of establishing a diagnosis.

3.8.2 PSYCHOLOGICAL TESTS

Personality test is a psychological test that measures personality characteristics. If the psychologist believes that personality characteristics are causes for psychological disorder. The best-known personality test is the *Minnesota Multiphasic Personality Inventory*
Intelligence Tests Although their results are often misinterpreted, **intelligence tests** are some of the most frequently used tests among psychologists. Created to predict success in school, these tests were designed to produce an **intelligence quotient**, or IQ , score. *Stanford-Binet Intelligence Scale* and the *Weschler Adult Intelligence Scale*, another widely used intelligence test.

Projective Tests Projective testing emerged from psychoanalytic theory. Two widely used projective tests are the *Rorschach Inkblot Test* and the *Thematic Apperception Test.*

Tests for Specific Symptoms In addition to tests of general psychological functioning, we also need assessment tools that provide reliable and valid measures of specific types of symptoms, such as depression and anxiety. Depressive symptoms, for example, are commonly assessed by the *Beck Depression Inventory–II*

3.8.3 BEHAVIORAL ASSESSMENT

This approach relies on applying the principles of learning to understand behavior, and its ultimate goal is a functional analysis (Haynes et al., 2006). When conducting a functional analysis (also known as *behavioral analysis* or *functional assessment*), the clinician attempts to identify causal (or functional) links between problem behaviors and contextual variables (e.g., environmental and internal variables that affect the problem behavior). To identify antecedents and consequences of behavior, a behavioral assessment often starts with a behavioral interview. The interviewer asks very specific questions to discover the full sequence of events and behaviors surrounding the patient's primary problems. **self-monitoring**, a process in which a patient observes and records his or her own behavior as it happens self-monitoring requires patients to record their symptoms when they occur, allowing real-time information about the frequency, duration, and nature of the symptoms. Self-monitoring can also create a record of how often problem behaviors are occurring before treatment begins and how symptoms change over time. Self-monitoring can also create a record of how often problem behaviors are occurring before treatment begins and how symptoms change over time.

PSYCHOPHYSIOLOGICAL ASSESSMENT

Psycho-physiological assessment measures brain structure, brain function, and nervous system activity. This type of assessment measures physiological changes in the nervous system that reflect emotional or psychological events. Different types of measurements assess a range of biochemical alterations in the brain or physiological changes in other parts of the body. One of the oldest, most common and least invasive types of psycho-physiological measurements is *electroencephalography* (EEG).

Check your progress

1. What is screening?
2. What is reliability?

3.9 The Classification of Abnormal Behavior

The goal of having a **classification system** for abnormal behaviors is to provide distinct categories, indicators, and nomenclature for different patterns of behavior, thought processes, and emotional disturbances. Thus the pattern of behavior classified as *paranoid schizophrenia* should be clearly different from the pattern named *borderline personality*.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

The end of the nineteenth century, Emil Kraepelin devised the first effective classification scheme for mental disorders. Kraepelin held the organic view of psychopathology, and his system had a distinctly biogenic slant. Classification was based on the patient's symptoms, as in medicine. It was hoped that disorders (similar groups of symptoms) would have a common *etiology* (cause or origin), would require similar treatments, would respond to those treatments similarly, and would progress similarly if left untreated. Many of these same expectations were held for the *Diagnostic and Statistical Manual of Mental Disorders*, based on the Kraepelinian system and published by the American Psychiatric Association in 1952. Each subsequent version of DSM was developed to have greater reliability and validity. In addition, DSM tried to incorporate new research findings. Although Kraepelin's concepts still formed the basis for some of its categories, successive versions of DSM contained substantial revisions. For example, to improve reliability, DSM specified the exact criteria that clinicians should use in making a diagnosis. The American Psychiatric Association published the latest version, *DSM-V*, in 2013.

3.10 Let's sum it up

The biological, psychodynamic, cognitive-behavioral, and humanistic approaches to understanding the causes of abnormal behavior are alternative paradigms, and not just alternative theories. Biological approaches emphasize causes "within the skin." Psychodynamic theory highlights unconscious processes. Cognitive-behavioral viewpoints focus on observable, learned behavior. The humanistic paradigm argues that behavior is a product of free will.

Biological factors in abnormal behavior begin with the neuron, or nerve cell. Communication between neurons occurs when the axon terminals release chemical substances called neurotransmitters into the synapse between nerve cells. Disrupted communication among neurons, particularly disruptions in the functioning of various neurotransmitters, is involved in several types of abnormal behavior, although you should be cautioned against mind–body dualism. Psychophysiology involves changes in the functioning of the body that result from psychological experiences.

Psycho-physiological arousal is caused by the endocrine system and the nervous system. Endocrine glands release hormones into the bloodstream that regulate some aspects of normal development as well as some responses to stress. The autonomic nervous system is the part of the central nervous system that is responsible for psycho-physiological reactions. Psychology has not developed a list of its core components. Some promise toward this goal is offered by evolutionary psychology, the application of the principles of evolution to our understanding of the animal and human minds. Two basic psychological motivations seen in humans and other animals are the formation of attachments and competition for dominance.

3.11 Unit End Exercise

1. Describe the biological model of abnormal behavior.
2. Describe the interview method in clinical assessment.
3. Write about DSM and its various editions.

3.12 Answers for check your progress

1. CAT means computerized axial tomography.
2. According to learning theory, *behavior* is the product of an individual's learning history. Abnormal behavior is therefore the result of maladaptive learning experiences.
3. Screenings can help identify people who have problems but who may not be aware of them or may be reluctant to mention them and/or those who may need further evaluation.
4. The reliability of an instrument is its consistency, or how well the measure produces the same result each time it is give Reliability is assessed in many ways.

3.13 Suggested Readings

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UNIT -4 DISORDERS OF CHILDHOOD & ADOLESCENCE

Structure

4.1 INTRODUCATION

Psychological disorders of childhood and adolescence often have a special poignancy, perhaps none more than autism. These disorders affect children at ages when they have little capacity to cope. Some of these problems, such as autism and intellectual disability (formerly called *mental retardation*), prevent children from fulfilling their developmental potentials. Some psychological problems in children and adolescents mirror those found in adults—problems such as mood disorders and anxiety disorders. In some cases, the problems are unique to childhood, such as separation anxiety; in others, such as ADHD, or attention-deficit/hyperactivity disorder, the problem manifests itself differently in childhood than in adulthood.

4.2 Objectives

After completing this unit, you should be able to understand the following concept

- Intellectual disability and its causes and treatment
- Autism Spectrum Disorder and its causes and treatment

4.3 Intellectual Disability

About 1% of the general population is affected by intellectual disability or ID (also called *intellectual developmental disorder* or *IDD*). The primary feature of ID is a general deficit in intellectual development. Formerly called *mental retardation,* intellectual disability is the diagnostic term applying to individuals who have significant and broad-ranging limitations or deficits in intellectual functioning and adaptive behaviors
(e.g., lack of basic conceptual, social, and practical skills of daily living). Children with
ID tend to have deficits in reasoning and problem-solving ability, abstract thinking skills, judgment, and school performance. Intellectual disability is diagnosed on the basis of a low IQ score and impaired adaptive functioning occurring before the age of 18 that results in significant impairments in meeting expected standards of independent functioning and social responsibility.

These impairments may involve difficulty performing common tasks of daily life expected of someone of the same age in a given cultural setting in three domains: (1) conceptual (skills relating to use of language, reading, writing, math, reasoning, memory, and problem solving), (2) social (skills relating to awareness of other people's experiences, ability to communicate effectively with others, and ability to form friendships, among others), and (3) practical (ability to meet personal care needs, fulfill job responsibilities, manage money, and organize school and work tasks, among others). Although earlier versions of the *DSM* required an IQ score of less than 70 (100 is the average score) for a diagnosis of mental retardation, *DSM-5* does not set any particular IQ score for the diagnosis of ID. The level of severity depends upon the child's adaptive functioning, or ability to meet the expectable demands children face at school and in the home. Most children with ID (about 85%) fall into the mild range. These children are generally capable of meeting basic academic demands, such as learning to read simple passages. As adults, they are generally capable of independent functioning, although they may require some guidance

4.4 Diagnostic criteria for intellectual disability

A. Significantly sub average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly sub average intellectual functioning).

B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.

C. The onset is before age 18 years.

Classification of Persons with Mental Retardation

Based on the 1983 AAMR definition, the operational classification for persons with mental retardation is as follows**:**

Level of Retardation	*IQ Range*
Mild	89 - 70
Moderate	70 - 31
Severe	30 -20
Profound	19 - 0

Educational Classification

In the special education centres in India, the classroom classification in operation is as shown below:

I. Pre-Primary (A) level	- Chronological ages 3 – 6 years - Mental ages Upto 5 years
II. Pre-Primary (B) level	- Chronological ages Over 6 years - Mental ages Around 4½ years
III. Primary level	- Chronological ages 7 – 10 years - Mental ages 5 – 7 years
IV. Secondary level	- Chronological ages 10 – 13 years - Mental ages 7 – 9 years

V. Pre-Vocational level - Chronological ages 14 – 16 years
- Mental ages 8 + years

4.5 Causes

There are literally hundreds of known causes of intellectual disability, including the following:

Environmental: For example, deprivation, abuse, and neglect
Prenatal: For instance, exposure to disease or drugs while still in the womb
Peri-natal: Such as difficulties during labor and delivery
Postnatal: For example, infections and head injury

Biological Dimensions

Most research on the causes of intellectual disability focuses on biological influences.

Genetic Influence: Almost 300 genes have been identified as having the potential to contribute to intellectual disability, and it is expected that there are many more A portion of the people with more severe intellectual disability have identifiable single-gene disorders, involving a *dominant gene* (expresses itself when paired with a normal gene), a *recessive gene* (expresses itself only when paired with another copy of itself), or an *X-linked gene* (present on the X or sex chromosome). Someone who carries a dominant gene that results in intellectual disability is less likely to have children and thus less likely to pass the gene to offspring.

Chromosomal Influences

Down syndrome and fragile X syndrome is the great examples for chromosome influences. **Down syndrome**, the most common chromosomal form of intellectual disability, was first identified by the British physician Langdon Down in 1866. The disorder is caused by the presence of an extra 21st chromosome and is therefore sometimes referred to as *trisomy 2.1*People with Down syndrome have characteristic facial features, including folds in the corners of their

upwardly slanting eyes, a fl at nose, and a small mouth with a flat roof that makes the tongue protrude somewhat.

Fragile X syndrome is a second common chromosomally related cause of intellectual disability. This disorder is caused by an abnormality on the X chromosome, a mutation that makes the tip of the chromosome look as though it were hanging from a thread, giving it the appearance of fragility. Fragile X primarily affects males because they do not have a second X chromosome with a normal gene to balance out the mutation. Men with the disorder display moderate to severe levels of intellectual disability and have higher rates of hyperactivity, short attention spans, gaze avoidance, and perseverative speech (repeating the same words again and again)

Psychological and Social Dimensions

Sometimes referred to as **cultural– familial intellectual disability**, people with these characteristics are thought to have cognitive impairments that result from a combination of psychosocial and biological influences, although the specific c mechanisms that lead to this type of intellectual disability are not yet understood. The cultural influences that may contribute to this condition include abuse, neglect, and social deprivation.

Treatment

Biological treatment of intellectual disability is currently not a viable option. Generally, the treatment of individuals with intellectual disability parallels that of people with pervasive developmental disorders, attempting to teach them the skills they need to become more productive and independent. For people with more severe disabilities, the general goals are the same; however, the level of assistance they need is often more extensive Individuals with intellectual disability can acquire skills through the many behavioral innovations. Communication training is important for people with intellectual disability. Making their needs and wants known is essential for personal satisfaction and for

participation in most social activities. Concern is often expressed by parents, teachers, and employers that some people with intellectual disability can be physically or verbally aggressive or may hurt themselves. In addition to ensuring that people with intellectual disability are taught specific skills, caretakers focus on the important task of supporting them in their community.

Check Your Progress

1. What is Intellectual Disability?
2. What is Down syndrome?

Autism Spectrum Disorder

Autism is one of the most severe behavioral disorders of childhood. It is a chronic, lifelong condition. The word *autism* derives from the Greek *autos*, meaning "self." The term was first used in 1906 by the Swiss psychiatrist Eugen Bleuler to refer to a peculiar style of thinking among people with schizophrenia. Autistic thinking is the tendency to view oneself as the center of the universe, to believe that external events somehow refer to oneself. In 1943, another psychiatrist, Leo Kanner, applied the diagnosis "early infantile autism" to a group of disturbed children who seemed unable to relate to others, as if they lived in their own private worlds. Unlike children with intellectual disability, these children seemed to shut out any input from the outside world, creating a kind of "autistic aloneness" (Kanner, 1943).

The *DSM-5* places autism (previously called *autistic disorder*) in a broader diagnostic category called autism spectrum disorder, or ASD, that includes a range of autism related disorders that vary in severity. *DSM-5* identifies ASD on the basis of a common set of behaviors representing persistent deficits in communication and social interactions and restricted or fixated interests and repetitive behaviors. Clinicians need to rate the severity of ASD as severe, moderate, or mild.

Diagnostic criteria for autism spectrum disorder

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history.

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history.
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).
C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning,

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Features of Autism

Three major characteristics of autism are expressed in *DSM-IV-TR:* impairment in social interactions; impairment in communication; and restricted behavior, interests, and activities (American Psychiatric Association, 2000).

Impairment in Social Interactions. One of the defining characteristics of people with autistic disorder is that they do not develop the types of social relationships expected for their age

Impairment in Communication. People with autism nearly always have severe problems with communicating. About one third never acquire speech. In those with some speech, much of their communication is unusual. Some repeat the speech of others. Some people with autism who can speak are unable or unwilling to carry on conversations with others.

Restricted Behavior, Interests, and Activities. The more striking characteristics of autism include restricted patterns of behavior, interests, and activities. people with autism spend countless hours in *stereotyped and ritualistic behaviors,* making such stereotyped movements as spinning around in circles, waving their hands in front of their eyes with their heads cocked to one side, or biting their hands

Causes:

Biological Dimensions

Genetic Infl uences.

It is now clear that autism has a genetic component the genes responsible for the brain chemical oxytocin. Because oxytocinis shown to have a role in how we bond with others and in our social memory.

Neurobiological Influences.

The amygdala—the area of the brain that, involved in emotions such as anxiety and fear. Earlier research showed that young children with autism actually have a larger amygdala. The theory being proposed is thatthe amygdala in children with autism is enlarged early in life—causing excessive anxiety and fear (perhaps contributing to their social withdrawal). With continued stress, the release of the stress hormone cortisol damages the amygdala, causing the relative absence of these neurons in adulthood. The damaged amygdala may account for the different way people with autism respond to social situations. An additional neurobiological influence we mentioned in the section on genetics involves the neuropeptide oxytocin. Remember that this isan important social neurochemical that influences bonding and is found to increase trust and reduce fear. Some research on children with autism found lower levels of oxytocin in their blood

Treatment

There is no completely effective treatment exists. Attempts to eliminate the social problems experienced by these individuals have not been successful to date.

Biological Treatments

A variety of pharmacological treatments are used to decrease agitation, and the major tranquilizers and serotonin-specific reuptake inhibitors seem helpful.

Integrating Treatments

The treatment of choice for people with autism disorder—combines various approaches to the many facets of this disorder. For children, most therapy consists of school education with special

psychological supports for problems with communication and socialization. Behavioral approaches have been most clearly documented as benefiting children in this area. Pharmacological treatments can help some of them temporarily. Parents also need support because of the great demands and stressors involved in living with and caring for such children.

Check your Progress

1. What is Autism?

Let's Sum Up

Mental retardation is defined as sub average intellectual functioning, as measured by an IQ score below 70 and deficits in adaptive behavioral functioning. There are four levels of mental retardation, ranging from mild to profound. A number of biological factors are implicated in mental retardation, including metabolic disorders (PKU, Tay-Sachs disease); chromosomal disorders (Down syndrome, fragile X, trisomy 13, and trisomy 18); prenatal exposure to rubella, herpes, syphilis, or drugs (especially alcohol, as in fetal alcohol syndrome); premature delivery; and head trauma (such as that arising from being shaken as an infant). There is some evidence that intensive and comprehensive educational interventions, administered very early in a child's life, can help decrease the level of mental retardation.

Autism is characterized by significant interpersonal, communication, and behavioral deficits. Many children with autism score in the mental retardation range on IQ tests. Outcomes of autism vary widely, although the majority of people with autism must receive continual care, even as adults. The best predictors of a good outcome in autism are an IQ above 50 and language development before age 6. Possible biological causes of autism include a genetic predisposition to cognitive impairment, central nervous system damage, prenatal complications, and neurotransmitter imbalances. Drugs reduce some symptoms in autism but do not eliminate the core of the disorder. Behavior therapy is used to reduce inappropriate and self-injurious behaviors and encourage pro social behaviors.

Unit End Exercise

1. Describe the effects of child abuse.
2. Describe key features of autism spectrum disorder and ways of understanding and treating it.
3. Describe the key features and causes of intellectual disability.

Answers for Check your Progress

1. Intellectual disability is the diagnostic term applying to individuals who have significant and broad-ranging limitations or deficits in intellectual functioning and adaptive behaviors (e.g., lack of basic conceptual, social, and practical skills of daily living).
2. The disorder is caused by the presence of an extra 21st chromosome and is therefore sometimes referred to as *trisomy 21*
3. *DSM-5* identifies ASD on the basis of a common set of behaviors representing persistent deficits in communication and social interactions and restricted or fixated interests and repetitive behaviors.

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UNIT 5

ANXIETY RELATED DISORDER

Structure

5.1 INTRODUCTION

Anxiety is complex and mysterious, as Sigmund Freud realized many years ago. The various forms of anxiety disorders—including phobias, obsessions, compulsions, and extreme worry—represent the most common type of abnormal behavior. Anxiety disorders lead to significant social and occupational impairment and reduced quality of life. Anxiety disorders share several important similarities with mood disorders. From a descriptive point of view, both categories are defined in terms of negative emotional accompany anxiety and depression

5.2 Objectives

On completion of this unit, you will be able to understand the following concepts

- Anxiety Disorder
- Somatoform disorder
- Mood disorder

5.3 Anxiety

Anxious mood is often defined in contrast to the specific emotion of fear, which is more easily understood. Fear is experienced in the face of real, immediate danger responses. Feelings such as guilt, worry, and anger frequently anxiety involves a more general or diffuse emotional reaction—beyond simple fear—that is out of proportion to threats from the environment (Barlow, 2004). Rather than being directed toward the person's present circumstances, anxiety is associated with the anticipation of future problems. Anxiety can be adaptive at low levels, because it serves as a signal that the person must prepare for an upcoming event. A pervasively anxious mood is often associated with pessimistic thoughts and feelings. Factors can be used to define anxious apprehension, which consists of (1) high levels of diffuse negative emotion, (2) a sense of uncontrollability, and (3) a shift in attention to a primary self-focus or a state of self preoccupation

5.3.1 SYMPTOMS OF ANXIETY DISORDERS

Excessive Worry: Worrying is a cognitive activity that is associated with anxiety. Worry can be defined as a relatively uncontrollable

sequence of negative, emotional thoughts that are concerned with possible future threats or danger.

Panic Attacks

A panic attack is a sudden, overwhelming experience of terror or fright, People undergoing a panic attack also report a number of cognitive symptoms. They may feel as though they are about to die, lose control, or go crazy.

Phobias:

Phobias are persistent, irrational, narrowly defined fears that are associated with a specific object or situation. Avoidance is an important component of the definition of phobias.

Obsessions and Compulsions

Obsessions are repetitive, unwanted, intrusive cognitive events that may take the form of thoughts or images or urges. They introduce suddenly into consciousness and lead to an increase in subjective anxiety. **Compulsions** are repetitive behaviors or mental acts that are used to reduce anxiety. Examples include checking many times to be sure that a door is locked

5.3.2 Causes for anxiety related disorder

Adaptive and Maladaptive Fears

Intense fear is triggered at an inappropriate time or place, these response systems can become more harmful than helpful. Social threats are more likely to provoke responses such as shyness and embarrassment that may increase acceptance by other people by making the individual seem less threatening.

Stressful Life Events

Common sense suggests that people who experience high stress levels are likely to develop negative emotional reactions. Stressful life events can influence the onset of anxiety disorders as well as depression. Patients with anxiety disorders are more likely than other people to report having experienced a negative event

Childhood Adversity:

Maternal prenatal stress, maternal partner changes, parental indifference (being neglected by parents), and physical abuse (being physically beaten or threatened with violence). Children who are exposed to higher levels of adversity are more likely to develop anxiety disorders later in their lives.

Attachment and Separation Anxiety

The anxiety is an innate response to separation, or the threat of separation, from the caretaker. Those infants who are insecurely attached to their parents are presumably more likely to develop anxiety disorders

Psychological Factors

COGNITIVE FACTOR

Cognitive events also play an important role as mediators between experience and response. Perceptions, memory, and attention all influence the ways that we react to events in our environments. It is now widely accepted that these cognitive factors play a crucial role in the development and maintenance of various types of anxiety disorders

Perception of Control:

There is an important relationship between anxiety and the perception of control. People who believe that they are able to control events in their environment are less likely to show symptoms of anxiety than are people who believe that they are helpless

Thought Suppression:

The struggle to control our thoughts often leads to a process known as *thought suppression,* an active attempt to stop thinking about something. Obsessive–compulsive disorder may be related, in part, to the maladaptive consequences of attempts to suppress unwanted or

threatening thoughts that the person has learned to see as being dangerous or forbidden.

Learning process

Many researchers suggested that fear is a learned one. During childhood we learned to fear to specific objects that develops the anxiety towards that particular object in later life. We learned so many fears from our immediate environment, that plays role in later life.

Biological Factors

Genetic Factors

Genetic factors that would be *unique* to individuals also play an important role in the etiology of all anxiety disorders. Genetic factors that would be *shared* by all members of a family do not seem to play an important role for many people.

Neurobiology

The specific brain pathways that are responsible for detecting and organizing a response to danger. The amygdale plays a central role in these circuits, which represent the biological underpinnings of the evolved fear module.
Anxiety disorder:

5.3.3 PANIC DISORDER AND AGORAPHOBIA

Panic attacks are the defining feature of two anxiety disorders: panic disorder without agoraphobia and panic disorder with agoraphobia. In panic disorder with agoraphobia, panic attacks are also a central feature. *Agoraphobia* (literally meaning "fear of the marketplace") is a fear of being in public places or situations where escape might be difficult or help unavailable if a panic attack occurs. People who have agoraphobia avoid public places, such as supermarkets; shopping malls; restaurants. Someone who has panic disorder without agoraphobia does not avoid situations (driving,

shopping, getting on a bus) because of the fear that a panic attack might occur

5.3.4 GENERALIZED ANXIETY DISORDER

The key feature of **generalized anxiety disorder** (GAD) is excessive worry occurring more days than not and lasting at least 6 months. People with GAD worry about future events, past transgressions, financial matters, and their own health and that of loved one

5.3.5 SOCIAL PHOBIA

Social Phobia is a severe fear of social or performance situations (APA, 2000a). Social situations that create distress include speaking, eating, drinking, or writing in the presence of others; engaging in social interactions such as parties or meetings; and simply initiating or maintaining conversations. When in these situations, people with social phobia fear that others will detect their anxiety through their speech or behavior

5.3.6 SPECIFIC PHOBIA

Specific Phobias are severe and persistent fears of circumscribed events, objects, or situations that lead to significant disruption in daily functioning

5.3.7 OBSESSIVE-COMPULSIVE DISORDER

OCD is a condition involving obsessions (intrusive thoughts), often combined with compulsions (repetitive behaviors) that can be extensive, time consuming, and distressful

5.3.8 POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder (PTSD) begins with a traumatic event such as military combat, assault, rape, or observation of the serious injury or violent death of another person. Later when confronting

events or situations that symbolize or resemble part of the trauma, such as a dark alley similar to the one where an assault

5.4 Somatoform Disorders

Somatoform disorders are defined as conditions in which physical symptoms or concerns about an illness cannot be explained by a medical or psychological disorder (e.g., depression or anxiety). People who suffer from somatoform disorders experience real physical symptoms, but their physical pain cannot be fully explained by an established medical condition. The somatoform disorders are a confusing diagnostic category because the individual disorders do not share an underlying emotion or a common etiology occurred, the person may suffer an intense psychological and physiological reaction. Specifically, what the disorders share is the *lack* of a recognizable medical cause for their physical distress. The six different somatoform disorders are somatization disorder, undifferentiated somatoform disorder, conversion disorder, pain disorder, hypochondriasis, and body dysmorphic disorder

5.4.1 COMMON FACTORS IN SOMATOFORM DISORDERS:

All somatoform disorders share certain features. Approximately 33 to 40% of people with a somatoform disorder also have coexisting anxiety and/or depressive disorders It is often a challenge to determine whether physical complaints represent a physical disorder, a psychological disorder such as depression, or the separate category of somatoform disorder.

FUNCTIONAL IMPAIRMENT

Somatoform disorders produce significant functional impairment Hypochondriasis and pain disorder increase the likelihood of physical disability, occupational impairment, and overutilization of health services (Aigner et al., 2003; Gureje et al.). People with BDD report severe social impairment; they are very often single, avoid dating, and are socially isolated Although many physical complaints lack an organic basis, they still have an enormous impact on our medical system.

Doctor-shopping is just one example of how somatoform disorders increase medical utilization and costs.

CAUSES

Biological factors would seem to play a role, particularly when distorted perceptual processes, such as those found in BDD, are apparent. One small study found that female patients with somatization disorder or undifferentiated somatoform disorder (*n* 5 10) had larger caudate nuclei volumes compared with healthy people.

Psychosocial Factors

Psychodynamic explanations for somatoform disorders propose that these disorders result from intra psychic conflict, personality, and defense mechanisms. Behavioral principles of modeling and reinforcement may also contribute to the development of illness behavior. Other environmental factors also are associated with physical symptoms, distress, and somatoform disorders. Among adults, stress was temporally associated with 72% of somatoform disorders. In contrast, a history of sexual abuse was present in 28% of the cases (Singh & Lee, 1997). Among children (Kozlowska et al., 2007), family separation/loss was associated with the onset of the disorder in 34% of the cases. Family conflict/ violence was associated in 20% of the cases, and sexual assault correlated in only 4%. The relationship between somatoform disorders and childhood sexual abuse is controversial (Alper et al., 1993; Coryell & Norten, 1981; Morrison, 1989; see the feature "Examining Other cognitive theories propose that somatoform disorders develop from inaccurate beliefs about the (a) prevalence and contagiousness of illnesses, (b) meani of bodily symptoms, and (c) course and treatment of illnesses (Salkovskis, 1989).

Check Your Progress

1.What is GAD? 2. What is OCD?

5.4.2 SOMATIZATION DISORDER

Somatization disorder, the condition is defined as the presence of many symptoms that suggest a medical problem but have no recognized organic basis the one most important symptom is pain, including back pain, joint pain arm or leg pain , headache, and abdominal pain Much less common but more dramatic are the pseudo seizures, which are sudden changes in behavior that mimic epileptic seizures but have no organic basis.

5.4.3 UNDIFFERENTIATED SOMATOFORM DISORDER

The symptoms are not explained by the presence of a medical condition and are not the result of injury, substance use, or medication side effect. When such physical complaints are present for at least 6 months and cause distress or functional impairment, the person may be suffering from undifferentiated somatoform disorder

5.4.4 CONVERSION DISORDER

A different somatoform disorder, conversion disorder, consists solely of pseudo neurological complaints such as motor or sensory dysfunction. Symptoms of conversion disorder can be quite dramatic, such as sudden paralysis or blindness. They are not intentionally produced and cannot be fully explained by the presence of any medical condition Symptoms of conversion disorder fall into three groups. The most common group includes *motor symptoms or deficits*, such as impaired coordination or balance, paralysis or weakness, difficulty swallowing, or a "lump in the throat," *aphonia* (loss of speech), or urinary retention *Sensory deficits*, a less common symptom group, include loss of touch or pain sensations, double vision or blindness, deafness, and hallucination Also rare is the third symptom group, which consists of behaviors such as *seizures and convulsions*.

5.4.5 PAIN DISORDER

Pain, which is a common human experience, is frustrating to both patients and health or mental health professionals. Pain can contribute to

the onset of psychological disorders or intensify conditions that are already present

5.4.5 HYPOCHONDRIASIS

Fears or concerns about having an illness persist despite medical reassurance, the problem may be **hypochondriasis**. People with hypochondriasis do not necessarily suffer from physical symptoms. Rather, they have a dysfunctional mind-set that leads to worry about health, illness, and physical symptoms

5.4.6 BODY DYSMORPHIC DISORDER

Body dysmorphic disorder (BDD) is an overwhelming concern that some part of the body is ugly or misshapen. Usually, if the concern is even minimally based in reality, it is an extreme exaggeration of a very minor flaw (e.g., avery small acne scar is described as a “huge crater on my face”).

5.5 Mood disorders

Mood disorders experience disturbances in mood that are unusually severe or prolonged and impair their ability to function in meeting their normal responsibilities. Some people become severely depressed even when things appear to be going well or when they encounter mildly upsetting events that others take in stride. Still others experience extreme mood swings. They ride an emotional roller coaster with dizzying heights and abysmal depths when the world around them remains largely on an even keel.

Types of Mood Disorders

The two major forms of mood disorders are depressive disorders and bipolar disorders (mood swing disorders). There are two major types of depressive disorders, *major depressive disorder* and *persistent depressive disorder,* and two major types of bipolar disorders, *bipolar disorder* and *cyclothymic disorder* (also called *cyclothymia*).

5.5.1 Major Depressive Disorder

The diagnosis of major depressive disorder (also called *major depression*) is based on the occurrence of at least one *major depressive episode* (MDE) in the absence of a history of mania or hypomania**.** A major depressive episode involves a clinically significant change in functioning involving a range of depressive symptoms, including depressed mood (feeling sad, hopeless, or "down in the dumps") and/or loss of interest or pleasure in all or virtually all activities for a period of at least two weeks (APA, 2013) Major depression is not simply a state of sadness or the blues. People with *major depressive disorder* (MDD) may have poor appetite, lose or gain substantial amounts of weight, have trouble sleeping or sleep too much, and become physically agitated or—at the other extreme—show a marked slowing down in their motor (movement) activity.

5.5.2 Persistent Depressive Disorder (Dysthymia)

Major depressive disorder is severe and marked by a relatively abrupt change from one's preexisting state and followed by remission after a period of a few weeks or months. But some forms of depression become chronic conditions that can last for years.

The diagnosis of persistent depressive disorder is used to classify cases of chronic lasting for at least two years. Persons with persistent depressive disorder may have either chronic major depressive disorder or a chronic but milder form of depression called *dysthymia.* Dysthymia typically begins in childhood or adolescence and tends to follow a chronic course through adulthood. The word *dysthymia* derives from Greek roots *dys-*, meaning "bad" or "hard," and *thymos,* meaning "spirit.

5.5.3 Bipolar Disorder

Bipolar disorder is characterized by extreme swings of mood and changes in energy and activity levels. Mood swings typically shift between the heights of elation to the depths of depression. The first episode may be either manic or depressive. Manic episodes typically last a few weeks or perhaps a month or two and are generally much shorter and end more abruptly than major depressive episodes. Some people

with bipolar disorder experience mixed states characterized by episodes of both mania and depression (APA, 2013). During these mixed states, the person's mood may rapidly shift between mania and depression (Swann et al., 2013).

5.5.4 Cyclothymic Disorder

Cyclothymia is derived from the Greek *kyklos,* which means "circle," and *thymos,* meaning "spirit." The notion of a circular-moving spirit is an apt description, because this disorder represents a chronic cyclical pattern of mood disturbance characterized by mild mood swings lasting at least two years (one year for children and adolescents). Cyclothymic disorder (also called *cyclothymia*) usually begins in late adolescence or early adulthood and persists for years. Few, if any, periods of normal mood last for more than a month or two. However, the periods of elevated or depressed mood are not severe enough to warrant a diagnosis of bipolar disorder. Although cyclothymic disorder may be the most common of the bipolar disorders, with reported prevalence rates ranging from about 0.4% to 1.0%, it tends to be under diagnosed in clinical practice (APA, 2013).

Check your Progress

3. What is hypochondriasis? 4. What is mood disorders? 5. What is dysthemia?

5.6 Let's Sum up

Anxiety consists of three components. The physiological components include sympathetic nervous system activation.
The cognitive or subjective component consists of negative thoughts, impulses, or images and a subjective feeling of anxious distress. The behavioral component is defined by escape from or avoidance of objects, situations, or events that create anxious distress. Anxiety is a common experience, and certain fears are common at various ages. However, to be considered an anxiety disorder, the fear or anxiety must cause significant distress and/or create functional impairment by interfering with common life activities. Anxiety disorders develop in many different

ways. Results of studies in molecular genetics, neurochemistry, and neuro-anatomy are now allowing researchers and clinicians to make advances in basic neuroscience and are providing unique insights into brain functioning.

Somatoform disorders are defined by the presence of physical symptoms or concerns about an illness that cannot be explained by an established medical or psychological disorder. Biological, psychological, and environmental factors may play a role in the onset of somatoform disorders. Dissociative disorders involve disruption in the integrated functions of consciousness, memory, identity, or perception, as in depersonalization, derealization, amnesia, or confusion or alteration of identity. Dissociative disorders are a controversial category of psychological dysfunction.

Mood disorders are disturbances in mood that are unusually prolonged or severe and serious enough to impair daily functioning. Mood disorders are divided into two major types: (1) unipolar disorders (major depressive disorder, persistent depressive disorder, and premenstrual dysphoric disorder, all of which are characterized by a downward mood disturbance); and (2) bipolar disorders (bipolar disorder and cyclothymic disorder), which are characterized by mood swings.

5.7 Unit End Exercise

1. Describe the physical, behavioral, and cognitive features of anxiety disorders.
2. Describe the key features and specific types of phobic disorders and explain how phobias develop.
3. Describe the key features of obsessive–compulsive disorder.
4. Describe the key features of somatic disorders.
5. Describe the key features of bipolar disorder and cyclothymic disorder.
6. Describe the key features of persistent depressive disorder.

5.8 Answers for check your Progress

1. The key feature of generalized anxiety disorder (GAD) is excessive worry occurring more days than not and lasting at least 6 months
2. OCD is a condition involving obsessions (intrusive thoughts), often combined with compulsions (repetitive behaviors) that can be extensive, time consuming, and distressful.
3. People with hypochondriasis do not necessarily suffer from physical symptoms. Rather, they have a dysfunctional mind-set that leads to worry about health, illness, and physical symptoms.
4. Mood disorders experience disturbances in mood that are unusually severe or prolonged and impair their ability to function in meeting their normal responsibilities.
5. Persons with persistent depressive disorder may have either chronic major depressive disorder or a chronic but milder form of depression called dysthymia.

5.9 Suggested Readings

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UNIT- 6

PSYCHOSIS: *PERSONALITY AND DEVELOPMENTAL DISORDER*

Structure

INTRODUCTION

In this unit we are discussing about various abnormal behaviors such as personality disorder, cognitive disorders and developmental disorder. Personality traits are influenced by various factors such as genetic, parenting style, environment etc. The personality disorder changes the entire lifestyle of the person. The impact of personality disorder is long lasting one. Second one is cognitive disorder, generally

it is known as old age problem. When the age increases the severity of the diseases also increased. There is no proven medicine for this disease. The last one is Developmental disorder. It affects during the developmental phase of the child. It creates lot of worries to the parents and teachers. Managing these children is a challenging one.

Objectives

By the end of this unit, you will be able to understand the following abnormal behavior

- Personality disorder
- Cognitive disorder
- Developmental disorder

PERSONALITY DISORDER

Personality disorders are considered separately from other forms of psychopathology in DSM-IV-TR. Most clinical disorders are listed on Axis I, whereas the personality disorders are listed on Axis II. All of the personality disorders are based on exaggerated personality traits that are frequently disturbing or annoying to other people The pattern must be evident in two or more of the following domains: cognition (such as ways of thinking about the self and other people), emotional responses, interpersonal functioning, or impulse control. This pattern of maladaptive experience and behavior must also be 1.Inflexible and pervasive across a broad range of personal and social situations. 2. The source of clinically significant distress or impairment in social, occupational, or other important areas of functioning. 3. Stable and of long duration, with an onset that can be traced back at least to adolescence or early adulthood. The concept of social dysfunction plays an important role in the definition of personality disorders. It provides a large part of the justification for defining these problems as mental disorders.

Symptoms

The specific symptoms that are used to define personality disorders represent maladaptive variations in several of the building blocks of

personality. These include motives, cognitive perspectives regarding the self and others, temperament, and personality traits.

Social Motivation

The concept of a motive refers to a person's desires and goals. Motives (either conscious or unconscious) describe the way that the person would like things to be, and they help to explain *why* people behave in a particular fashion. For example, a man might have neglected to return a telephone call because he wanted to be alone (rather than because he forgot that someone had called). Two of the most important motives in understanding human personality are affiliation—the desire for close relationships with other people—and power—the desire for impact, prestige, or dominance. Individual differences with regard to these motives have an important influence on a person's health and adjustment. Many of the symptoms of personality disorders can be described in terms of maladaptive variations with regard to needs for affiliation and power

Cognitive Perspectives Regarding Self and Others

Our social world also depends on mental processes that determine knowledge of ourselves and other people. Distortions of these mechanisms are associated with personality disorders are described in terms of maladaptive variations with regard to needs for affiliation and power. When we misperceive the intentions and motives and abilities of other people, our relationships can be severely disturbed.
Paranoid beliefs are one example

Temperament and Personality Traits

If motivation helps to explain *why* people behave in certain ways, temperament and personality traits describe *how* they behave. Temperament refers to a person's most basic, characteristic styles of relating to the world, especially those styles that are evident during the first year of life Problems may arise in association with extreme variations in either direction (high or low). Dramatically elevated levels of anger–hostility, impulsiveness, and excitement seeking are

particularly important, as are extremely low levels of trust, compliance, and tender mindedness.

Context and Personality

Two important qualifications must be made about the development and persistence of individual differences in temperament and personality. First, these differences may not be evident in all situations. Some important personality features may be expressed only under certain challenging circumstances that require or facilitate a particular response.

Personality disorders are divided into three groups. They are cluster A, cluster B cluster C

Cluster A Personality Disorders

Cluster A includes three disorders: paranoid, schizoid, and schizotypal forms of personality disorder. The behavior of people who fit the subtypes in this cluster is typically odd, eccentric, or asocial.

Paranoid personality disorder is characterized by the pervasive tendency to be inappropriately suspicious of other motives and behaviors.

Schizoid personality disorder is defined in terms of a pervasive pattern of indifference to other people, coupled with a diminished range of emotional experience and expression. These people are loners; they prefer social isolation to interactions with friends or family.

Schizotypal personality disorder Centers around peculiar patterns of behavior rather than on the emotional restriction and social withdrawal that are associated with schizoid personality disorder. Many of these peculiar behaviors take the form of perceptual and cognitive disturbance.

Cluster B Personality Disorder

Cluster B includes antisocial, borderline, histrionic, and narcissistic personality disorders. These disorders are characterized by dramatic, emotional, or erratic behavior.

Antisocial personality disorder is defined in terms of a persistent pattern of irresponsible and antisocial behavior that begins during childhood or adolescence and continues into the adult years.

Borderline personality disorder is a diffuse category whose essential feature is a pervasive pattern of instability in mood and interpersonal relationships. People with this disorder find it very difficult to be alone.

Histrionic personality disorder is characterized by a pervasive pattern of excessive emotionality and attention seeking behavior. People with this disorder thrive on being the center of attention.

Cluster C Personality disorder

Cluster C includes avoidant, dependent, and obsessive–compulsive personality disorders. The common element in all three disorders is presumably anxiety or fearfulness.

Avoidant personality disorder is characterized by a pervasive pattern of social discomfort, fear of negative evaluation, and timidity. People with this disorder tend to be socially isolated when outside their own family circle because they are afraid of criticism.

Dependent personality disorder is a pervasive pattern of submissive and clinging behavior. People with this disorder are afraid of separating from other people on whom they are dependent for advice and reassurance.

Obsessive–compulsive personality disorder (OCPD) is defined by a pervasive pattern of orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency. People with this disorder set ambitious standards for their own performance that frequently are so high as to be unattainable.

Check Your Progress

1. What is cluster A personality disorder?
2. Name the personality disorders in cluster C

COGNITIVE DISORDER

Introduction:

Dementia and delirium are the most frequent disorders found among elderly psychiatric patients. It is a clinical syndrome that involves progressive impairment of many cognitive abilities. Cognitive processes, including perception and attention, are related to many types of mental disorders Cognitive disorders are often associated with specific identifiable changes in brain tissue. Because of the close link between cognitive disorders and brain disease, patients with these problems are often diagnosed and treated by **neurologists,** physicians who deal primarily with diseases of the brain and the nervous system. Multidisciplinary clinical teams study and provide care for people with dementia and amnestic disorders. **Neuropsychologists** have particular expertise in the assessment of specific types of cognitive impairments. This is true for clinical assessments as well as for more detailed laboratory studies for research purposes.

Dementia, delirium, and amnestic disorders are listed as Cognitive Disorders in DSM-IV-TR.

Dementia is a gradual worsening loss of memory and related cognitive functions, including the use of language, as well as reasoning and decision making. It is a clinical syndrome that involves progressive impairment of many cognitive abilities

Delirium is a confusion state that develops over a short period of time and is often associated with agitation and hyperactivity. The most important symptoms of delirium are disorganized thinking and a reduced ability to maintain and shift attention (Gupta et al., 2008).

Delirium and dementia are produced by very different processes.

Dementia is a chronic, deteriorating condition that reflects the gradual loss of neurons in the brain. Delirium is caused by medical problems, such as infection, or of the side effects of medication.

A**mnestic disorders** experience memory impairments that are more limited than those seen in dementia or delirium. The person loses the ability to learn new information or becomes unable to recall previously learned information, but other higher level cognitive abilities—including the use of language are unaffected.

Check Your Progress

3. What is Dementia? 4. What is Delirium?

DEVELOPMENTAL DISORDER

Introduction

Childhood is considered particularly important because the brain changes significantly for several years after birth; this is also when critical developments occur in social, emotional, cognitive, and other important competency areas. These changes mostly follow a pattern: The child develops one skill before acquiring the next. Although this pattern of change is only one aspect of development, it is an important concept at this point because it implies that any disruption in the development of early skills will, by the very nature of this sequential process, disrupt the development of later skills.

Attention Deficit/Hyperactivity Disorder

Do you know people who flit from activity to activity, who start many tasks but seldom finish one, who have trouble concentrating, and who don't seem to pay attention when others speak? These people may have **attention deficit/ hyperactivity disorder (ADHD)**, one of the most common reasons children are referred for mental health services in the United States (Durand, 2011; Greenhill & Hechtman, 2009). The primary characteristics of such people include a pattern of inattention, such as not paying attention to school- or work-related tasks, or of hyperactivity and impulsivity. These deficits can significantly disturb academic efforts and social relationships.

DSM IV-TR differentiates three types of symptoms. The first includes problems of *inattention.* People may appear not to listen to others; they may lose necessary school assignments, books, or tools; and they may not pay enough attention to details, making careless mistakes. The second type of symptom includes *hyperactivity,* which includes

fidgeting, having trouble sitting for any length of time, and always being on the go. The third general symptom is *impulsivity,* which includes blurting out answers before questions have been completed and having trouble waiting.

Learning disorder

Parents often invest a great deal of time, resources, and emotional energy to ensure their children's academic success, it can be extremely upsetting when a child with no obvious intellectual deficits does not achieve as expected. In this section, we describe learning disorders in reading, mathematics, and written expression—all characterized by performance that is substantially below what would be expected given the person's age, intelligence quotient (IQ) score, and education. Similarly, *DSM-IV-TR* defines a mathematics disorder as achievement below expected performance in mathematics and defines a disorder of written expression as achievement below expected performance in writing. In each of these disorders, the difficulties are sufficient to interfere with the students' academic achievement and to disrupt daily activities. People with pervasive developmental disorders experience problems with language, socialization, and cognition (Durand, 2011). The word *pervasive* means that these problems are not relatively minor but significantly affect individuals throughout their lives. Included under the heading of pervasive developmental disorders are autistic disorder (or autism), Asperger's disorder, Rett's disorder, childhood is integrative disorder, and pervasive developmental disorder not otherwise specified. We focus on two of the more prevalent pervasive developmental disorders—autistic disorder and Asperger's disorder;

Autistic Disorder

Autistic disorder (autism) is a childhood disorder characterized by significant impairment in social interactions and communication and by restricted patterns of behavior, interest, and activities (Durand, 2011). Individuals with this disorder have a puzzling array of symptoms. Three major characteristics of autism are expressed in *DSM-IV-TR:* impairment in social interactions; impairment in communication; and restricted behavior, interests, and activities (American Psychiatric Association, 2000).

Asperger's Disorder

Asperger's disorder involves a significant impairment in the ability to engage in meaningful social interaction, along with restricted and repetitive stereotyped behaviors but without the severe delays in language or other cognitive skills characteristic of people with autism (American Psychiatric Association, 2000). First described by Hans Asperger in 1944, it was Lorna Wing in the early 1980s who recommended that Asperger's disorder be reconsidered as a separate disorder from autism, with an emphasis on the unusual and limited interests (such as train schedules) displayed by these individuals (Volkmar et al., 2009).

Intellectual disability

ID (previously referred to as mental retardation) is a disorder evident in childhood as significantly below-average intellectual and adaptive functioning (Toth & King, 2010). People with intellectual disability experience difficulties with day-to-day activities to an extent that reflects both the severity of their cognitive deficits and the type and amount of assistance they receive. We already studied detailed in previous unit.

Check Your Progress

5. What is Asperger's Syndrome?
6. What is Autism?

Let's Sum Up

DSM-IV-TR includes 10 personality disorders that are divided into three clusters: Cluster A (odd or eccentric) includes paranoid, schizoid, and schizotypal personality disorders; Cluster B (dramatic, emotional, or erratic) includes antisocial, borderline, histrionic, and narcissistic personality disorders; and Cluster C (anxious or fearful) includes avoidant, dependent, and obsessive compulsive personality disorders. Schizophrenia is characterized by a broad spectrum of cognitive and emotional dysfunctions that include delusions and hallucinations, disorganized speech and behavior, and inappropriate emotions.

The symptoms of schizophrenia can be divided into positive, negative, and disorganized. Positive symptoms are active manifestations of abnormal behavior, or an excess or distortion of normal behavior, and

include delusions and hallucinations. Negative symptoms involve deficits in normal behavior on such dimensions as affect, speech, and motivation. Disorganized symptoms include rambling speech, erratic behavior, and inappropriate affect. A number of causative factors have been implicated for schizophrenia, including genetic influences, neurotransmitter imbalances, structural damage to the brain caused by a prenatal viral infection or birth injury, and psychological stressors. Delirium is a temporary state of confusion and disorientation that can be caused by brain trauma, intoxication by drugs or poisons, surgery, and a variety of other stressful conditions, especially among older adults. Dementia is a progressive and degenerative condition marked by gradual deterioration of a range of cognitive abilities including memory, language, and planning, organizing, sequencing, and abstracting information. Alzheimer's disease is the leading cause of dementia, affecting approximately 4 million Americans; there is currently no known cause or cure. Amnestic disorders involve a dysfunction in the ability to recall recent and past events. The most common is Wernicke-Korsakoff syndrome, a memory disorder usually associated with chronic alcohol abuse.

Developmental psychopathology is the study of how disorders arise and change with time. These changes usually follow a pattern, with the child mastering one skill before acquiring the next. This aspect of development is important because it implies that any disruption in the acquisition of early skills will, by the very nature of the developmental process, also disrupt the development of later skills.

Unit End Exercise

1. Explain pervasive developmental disorders
2. What is cognitive disorders? Explain.
3. What is Antisocial personality disorder? Explain with examples.
4. Describe Intellectual disability

Answers for check your progress

1. Cluster A includes three disorders: paranoid, schizoid, and schizotypal forms of personality disorder. The behavior of people who fit the subtypes in this cluster is typically odd, eccentric, or asocial.

2.Cluster C includes avoidant, dependent, and obsessive–compulsive personality disorders

3. Dementia is a chronic, deteriorating condition that reflects the gradual loss of neurons in the brain.

4. Delirium is caused by medical problems, such as infection, or of the side effects of medication.

5. Asperger's disorder involves a significant impairment in the ability to engage in meaningful social interaction, along with restricted and repetitive stereotyped behaviors but without the severe delays in language or other cognitive skills characteristic of people with autism.

6. Autistic disorder (autism) is a childhood disorder characterized by significant impairment in social interactions and communication and by restricted patterns of behavior, interest, and activities .

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UNIT 7

THE CONSUMER DECISION MAKING PROCESS

Structure

7.1 Introduction

Decision making is essential phenomena in human life. In daily activities we have to make decisions for simple to complex activities. The success and failure of any endeavor depends upon the decision we make. Communication and leadership are the two factors which helps the individual to make decision wisely.

7.2 Objectives

On completion of this unit, you will be able to understand the following concepts

- Decision making
- Communication
- Leadership

7.3 Decision Making Process

Decisions are responses to problems— differences between what is and what could or should be. These problems can vary in importance from figuring out which job you should accept after graduation to deciding which brand of toothpaste to buy.

7.3.1 7 SIX STEPS OF DECISION MAKING

1 **Recognize and define the problem:** Perceiving a discrepancy between what is and what could or should be is called *problem recognition* and provides the foundation for all individual decision making. Defining the problem correctly is critical to successful individual decision making. However, because problem recognition is a perceptual process, managers do not always accurately assess the problems at hand.

There are several reasons they make this mistake: (a) They define the problem by available solutions, (b) they focus on aspects of problems they know they can solve and ignore larger, more difficult, issues, or (c) they diagnose problems in terms of the most obvious symptoms..

2. Identify and weight criteria: The rational decision maker identifies criteria necessary to make a decision. Given that most decisions require accomplishing more than one objective, the criteria must also be weighted to determine the relevant value of each identified criterion.

3. Search for information: If a perceived discrepancy is important, then the decision maker will implement a third stage of the decision-making process: determining why the problem occurred. This involves gathering information about the problem or discrepancy and possible ways to solve it. At the end of this process, the decision maker should have a

clear understanding of the problem and should have collected sufficient information to begin the fourth phase of the decision-making process.

4. Generate alternatives: In this phase of individual decision making, the decision maker develops or identifies potential courses of action. This phase requires transforming the information that was previously gathered into a set of alternatives. Identifying these alternatives is a difficult task that requires considerable creativity and mental flexibility

5. Compute the optimal decision: When a sufficient number of alternatives have been identified, it's time to evaluate them and make a choice. Either the decision maker can compare each alternative to every other alternative, or the decision maker can weigh each alternative in the con-text of the desired goal.

6. Implement and assess the decision: When a choice has been made, the decision maker must implement the decision. The process of making a choice is important, but decisions are worthless unless implemented.

7.3.2 DECISION ENVIRONMENTS

Problem-solving decisions are typically made under three different conditions or environments: certainty, risk, and uncertainty. **Certain environments** exist when information is sufficient to predict the results of each alternative in advance of implementation. When a person invests money in a savings account, for example, absolute certainty exists about the interest that will be earned on that money in a given period of time. Certainty is an ideal condition for managerial problem solving and decision making. The challenge is simply to locate the alternative offering the best or ideal solution.

Risk environments exist when decision makers lack complete certainty regarding the outcomes of various courses of action, but they are aware of the probabilities associated with their occurrence. A *probability*, in turn, is the degree of likelihood of an event's occurrence. Probabilities can be assigned through objective statistical procedures or through personal intuition. **Uncertain environments** exist when managers have so little information on hand that they cannot even assign probabilities to various alternatives and their possible outcomes. This is the most difficult of the three decision environments. Uncertainty forces decision

makers to rely heavily on individual and group creativity to succeed in problem solving. It requires unique, novel, and often totally innovative alternatives to existing patterns of behavior. Responses to uncertainty are often heavily influenced by intuition, educated guesses, and hunches.

7.3.3 TYPES OF DECISIONS

The many routine and non routine problems in the modern workplace call for different types of decisions. Routine problems arise on a regular basis and can be addressed through standard responses, called **programmed decisions**. These decisions simply implement solutions that have already been determined by past experience as appropriate for the problem at hand. Examples of programmed decisions are reordering inventory automatically when stock falls below a predetermined level. Non routine problems are unique and new, having never been encountered before. Because standard responses are not available, these circumstances call for creative problem solving.

These **non programmed decisions** are specifically crafted or tailored to the situation at hand. Higher level managers generally spend a greater proportion of their decision-making time on non routine problems. An example is a senior marketing manager who has to respond to the introduction of a new product by a foreign competitor. Although past experience may help deal with this competitive threat.

Associative choices are decisions that can be loosely linked to nagging continual problems but that were not specifically developed to solve the problem. Given the chaotic nature of the setting, the necessity to take action as opposed to waiting, and the ability of employees to make nearly any "decision" work, a stream of associative choices may be used to improve the setting, even though the problems are not solved.

7.3.4 Decision Making Models

The field of organizational behavior historically emphasizes two alternative approaches to decision making—classical and behavioral theory.

Classical decision theory models view the manager as acting in a world of complete certainty. **Behavioral decision theory** models accept the

notion of bounded rationality and suggest that people act only in terms of what they perceive about a given situation.

CLASSICAL AND BEHAVIORAL DECISION THEORY

Ideally, the manager faces a clearly defined problem, knows all possible action alternatives and their consequences, and then chooses the alternative that offers the best, or “optimum,” solution to the problem. This optimizing style is an ideal way to make decisions. This classical approach is normative and prescriptive, and is often used as a model for how managers should make decisions. Behavioral scientists are cautious about applying classical decision theory to many decision situations. They recognize that the human mind is a wonderful creation, capable of infinite achievements.

Human decision makers also operate with *bounded rationality*. Bounded rationality is a short-hand term suggesting that, while individuals are reasoned and logical, humans have their limits. Individuals interpret and make sense of things within the context of their personal situation. They engage in decision making “within the box” of a simplified view of a more complex reality. This makes it difficult to realize the ideal of classical decision making.

Behavioral decision theory models accept the notion of bounded rationality and suggest that people act only in terms of what they perceive about a given situation. Because these perceptions are frequently imperfect, most organizational decision making does not take place in a world of complete certainty. Rather, the behavioral decision maker is viewed as acting most often under uncertain conditions and with limited information. Organizational decision makers face problems that are often ambiguous, and they have only partial knowledge of the available action alternatives and their consequences.

THE GARBAGE CAN MODEL

A third view of decision making stems from the so-called **garbage can model**. In this view, the main components of the choice process—problems, solutions, participants, and choice situations—are all mixed up together in the “garbage can” of the organization. In many organizations where the setting is stable and the technology is well

known and fixed, tradition, strategy, and the administrative structure help order the contents of the garbage can. Specific problems can be matched to specific solutions, an orderly process can be maintained, and the behavior view of decision making may be appropriate.

But when the setting is dynamic, the technology is changing, demands are conflicting or the goals are unclear, things can get mixed up. More action than thinking can take place. Solutions emerge as "potential capabilities"—capabilities independent of problems or opportunities. Solutions often emerge not to solve specific problems but as lessons learned from the experience of other organizations.

Choice making and implementation may be done by quite different individuals. Often, the job of subordinates is to make the decisions of senior manager work. They must interpret the intentions of their bosses as well as solve local problems. Implementation becomes an opportunity to instill many changes related to the choice of more senior executives. So what is chosen gets implemented along with many other changes.

Check your Progress

1. What is certain environment?
2. What is programmed decision?

7.4 THE COMMUNICATION PROCESS

It is useful to think of **communication** as a process of sending and receiving, messages with attached meanings. They include a *source*, who encodes an intended meaning into a message, and a *receiver*, who decodes the message into a perceived meaning. The receiver may or may not give feedback to the source. Though this process may appear to be very elementary, it is not quite as simple as it looks. The information source is a person or group trying to communicate with someone else. The source seeks to communicate, in part, to change the attitudes, knowledge, or behavior of the receiver.

This involves *encoding*— the process of translating an idea or thought into a message consisting of verbal, written, or nonverbal symbols (such as gestures), or some combination of them. Such messages are transmitted through various **communication channels**, such as face-to-face meetings, electronic mail and other forms, written

letters or memorandums, and telephone communications or voice-mail, among others. The choice of channel can have an important impact on the communication process. Some people are better at using certain channels over others, and some messages are better handled by specific channels.

The communication process is not completed just because a message is sent. The receiver is the individual or group of individuals to whom a message is directed. In order for meaning to be assigned to any received message, its contents must be interpreted through *decoding*. This process of translation is complicated by many factors, including the knowledge and experience of the receiver and his or her relationship with the sender. A message may also be interpreted with the added influence of other points of view, such as those offered by friends, coworkers, or organizational superiors. Ultimately, the decoding may result in the receiver interpreting a message in a way that is different from that originally intended by the source.

Essentials of Interpersonal Communication

Organizations today are information rich. They are also increasingly "high-tech." But, we always need to remember that people still drive the system. And if people are to work together well and commit their mutual talents and energies to create high performance organizations, they must excel at interpersonal communication.

EFFECTIVE AND EFFICIENT COMMUNICATION

When people communicate with one another, at least two important things are at issue. One is the accuracy of the communication—an issue of effectiveness; the other is its cost—an issue of efficiency.

Effective communication occurs when the intended meaning of the source and the perceived meaning of the receiver are virtually the same. Although this should be the goal in any communication, it is not always achieved. Even now, we worry about whether or not you are interpreting these written words exactly as we intend. Our confidence would be higher if we were face to face in class together and you could ask clarifying questions. Opportunities to offer feedback and ask

questions are important ways of increasing the effectiveness of communication.

Efficient communication occurs at minimum cost in terms of resources expended. Time, for example, is an important resource. As efficient as these forms of communication may be, they are not always effective. A change in policy posted by efficient E-mail may save time for the sender, but it may not achieve the desired interpretations and responses. Similarly, an effective communication may not be efficient. For a business manager to visit each employee and explain a new change in procedures may guarantee that everyone understands the change, but it may also be prohibitively expensive in terms of the required time expenditure.

7.4.1 NONVERBAL COMMUNICATION

We all know that people communicate in ways other than the spoken or written word. Indeed, **nonverbal communication** that takes place through facial expressions, body position, eye contact, and other physical gestures is important both to understand and master. It is basically the act of speaking without using words. The nonverbal side to communication can often hold the key to what someone is really thinking or meaning. It can also affect the impressions we make on others. Interviewers, for example, tend to respond more favorably to job candidates whose nonverbal cues, such as eye contact and erect posture, are positive than to those displaying negative nonverbal cues, such as looking down or slouching. The art of impression management during interviews and in other situations requires careful attention to both verbal and nonverbal aspects of communication, including one's dress, timeliness, and demeanor. Nonverbal communication can also take place through the physical arrangement of space, such as that found in various office layouts. *Proxemics*, the study of the way space is utilized, is important to communication.

ACTIVE LISTENING

The ability to listen well is a distinct asset to anyone whose job involves a large proportion of time spent "communicating" with other people. After all, there are always two sides to the communication

process: (1) sending a message, or "telling," and (2) receiving a message, or "listening." There is legitimate concern that too many people emphasize the telling and neglect the listening. Everyone in the new workplace should develop good skills in **active listening**—the ability to help the source of a message say what he or she really means. The concept comes from the work of counselors and therapists, who are trained to help people to express themselves to others and talk about things that are important to them.

7.4.2 COMMUNICATION BARRIERS

It is important to understand six sources of noise that are common to most interpersonal exchanges: physical distractions, semantic problems, mixed messages, cultural differences, absence of feedback, and status effects.

PHYSICAL DISTRACTIONS

Any number of physical distractions can interfere with the effectiveness of a communication attempt. Physical interruptions such as telephone, drop-in visitors, and the like, should be prevented.

SEMANTIC PROBLEMS

Semantic barriers to communication involve a poor choice or use of words and mixed messages. Carefully read the following instructions, "We solicit any recommendations that you wish to make, and you may be assured that any such recommendations will be given our careful consideration." One has to wonder why these messages weren't stated more simply as: "Send us your recommendations. They will be carefully considered," In this regard, the popular KISS principle of communication is always worth remembering: "Keep it short and simple."

MIXED MESSAGES

Mixed messages occur when a person's words communicate one thing while actions or "body language" communicate another. They are important to spot since nonverbal can add important insight into what is really being said in face-to-face communication. For instance, someone may voice a cautious "Yes" during a business meeting at the same time

that her facial expression shows stress and she begins to lean back in her chair.

CULTURAL DIFFERENCES

People must always exercise caution when they are involved in cross-cultural communication—whether between persons of different geographical or ethnic groupings within one country, or between persons of different national cultures. The difficulties with cross-cultural communication are perhaps most obvious in respect to language differences. Gestures may also be used quite differently in the various cultures of the world. For example, crossed legs in the United Kingdom are quite acceptable, but are rude in Saudi Arabia if the sole of the foot is directed toward someone.

ABSENCE OF FEEDBACK

One-way communication flows from sender to receiver only, as in the case of a written memo or a voice-mail message. There is no direct and immediate feedback from the recipient. Two-way communication, by contrast, goes from sender to receiver and back again. It is characterized by the normal interactive conversations in our daily experiences. Research indicates that two-way communication is more accurate and effective than is one-way communication. One-way messages are easy for the sender but often frustrating for the receiver, who may be left unsure of just what the sender means or wants done.

STATUS EFFECTS

Status differences in organizations create potential communication barriers between persons of higher and lower ranks. On the one hand, given the authority of their positions, managers may be inclined to do a lot of "telling" but not much "listening." On the other hand, we know that communication is frequently biased when flowing upward in organizational hierarchies. Subordinates may *filter* information and tell their superiors only what they think the boss wants to hear. The higher level decision maker may end up taking the wrong actions because of biased and inaccurate information supplied from below. This is sometimes called the MUM effect in reference to tendencies to sometimes keep "mum" from a desire to be polite and a reluctance to transmit bad news.

Check your Progress

3. What is encoding?
4. What is nonverbal communication?
5. What is proxemics?

7.5 LEADERSHIP

Yukl and Van Fleet (1992) define leadership as ‘‘a process that includes influencing the task objectives and strategies of an organization, influencing people in the organization to implement the strategies and achieve the objectives, influencing the group maintenance and identification, and influencing the culture of the organization. Vroom and Jago (2007) have recently defined leadership more succinctly as ‘‘a process of motivating people to work together collaboratively to accomplish great things’. There are several things to note about these definitions. First, leadership involves the influencing of others' behaviors. Second, leadership is viewed as a process and not as an outcome. It is possible, based on this definition, for a leader to engage in unsuccessful influence attempts. Third, these definitions imply that leadership requires a variety of skills. Influencing task objectives and strategy may require strong analytical and conceptual skills; influencing people to implement those strategies and objectives requires interpersonal and persuasive skills.

Trait Leadership Perspectives

For over a century scholars have attempted to identify the key characteristics that separate leaders from non leaders. Much of this work stressed traits. **Trait perspectives** assume that traits play a central role in differentiating between leaders and non leaders in that leaders must have the "right stuff." The *great person-trait approach* reflects the attempt to use traits to separate leaders from non leaders. This list of possible traits identified only became longer as researchers focused on the leadership traits linked to successful leadership and organizational performance. Key traits of leaders include ambition, motivation, honesty, self-confidence, and a high need for achievement. Leaders must be able to deal with the large amount of information they receive on a regular basis. They do not need to be brilliant, but usually exhibit above-

average intelligence. In addition, leaders have a good understanding of their social setting and possess extensive knowledge concerning their industry, firm, and job.

Behavioral Leadership Perspectives

The **behavioral perspective** assumes that leadership is central to performance and other outcomes. However, instead of underlying traits, behaviors are considered. Two classic research programs—at the University of Michigan and at the Ohio State University— provide useful insights into leadership behaviors.

Michigan Studies In the late 1940s, researchers at the University of Michigan sought to identify the leadership pattern that results in effective performance. From interviews of high- and low-performing groups in different organizations, the researchers derived two basic forms of leader behaviors: employee-centered and production-centered. Employee-centered supervisors are those who place strong emphasis on their subordinates' welfare. In contrast, production-centered supervisors are more concerned with getting the work done. In general, employee centered supervisors were found to have more productive workgroups than did the production-centered supervisors.

Ohio State Studies At about the same time as the Michigan studies, an important leadership research program began at the Ohio State University. A questionnaire was administered in both industrial and military settings to measure subordinates' perceptions of their superiors' leadership behavior. The researchers identified two dimensions similar to those found in the Michigan studies: **consideration** and **initiating structure**. A highly considerate leader was found to be sensitive to people's feelings and, much like the employee-centered leader, tries to make things pleasant for his or her followers. In contrast, a leader high in initiating structure was found to be more concerned with defining task requirements and other aspects of the work agenda; he or she might be seen as similar to a production-centered supervisor. These dimensions are related to what people sometimes refer to as socio-emotional and task leadership, respectively.

7.5.1 TYPES OF LEADERS

Leadership appears in two forms: (1) *formal leadership*, which is exerted by persons appointed or elected to positions of formal authority in organizations, and (2) *informal leadership*, which is exerted by persons who become influential because they have special skills that meet the needs of others.

Directive leadership has to do with spelling out the subordinates' tasks; it is much like the initiating structure mentioned earlier.

Supportive leadership focuses on subordinate needs and well-being and on promoting a friendly work climate; it is similar to consideration.

Achievement oriented leadership emphasizes setting challenging goals, stressing excellence in performance, and showing confidence in the group members' ability to achieve high standards of performance.

Participative leadership focuses on consulting with subordinates, and seeking and taking their suggestions into account before making decisions.

7.5.2 The importance of Leaders

Leaders are often needed to provide strategic direction and vision to groups and, in many cases, to entire organizations (Bass, 1998). Work-group members are often too busy with routine task completion, and with meeting deadlines, to think about where the group is headed in the future. In many groups, strategic planning and visioning activities are shared among group members, but the leader is typically the focal point of such efforts. In a sense, then, leaders help organizations to channel productive behavior in directions that are beneficial and that meet relevant strategic objectives. Another important function of leaders, particularly those in small groups, is to engage in motivation and coaching behaviors. Even highly experienced employees occasionally need encouragement and, in some cases, help in solving difficult work related problems. A third important function of leaders in organizations is enforcement and interpretation of organizational policies. For most employees, leaders serve as ''linking pins'' to people in higher levels of the organization (Likert, 1967). Because of this concept, leaders are often required to interpret and enforce organizational policies. Finally, leaders are important because they are

typically responsible for obtaining resources for groups. Leaders essentially represent the interests of their work groups within the broader organizational environment. Because of this, groups often rely heavily on the persuasive skills of leaders to obtain resources for task completion. Without a leader, the members of a group may all be trying to obtain resources and, at times, may get in each other's way.

7.6 Let's Sum Up

Because human beings make thousands of decisions every day, the process of decision making appears to be deceptively simple. On closer examination, however, it becomes clear that when done well, decision making is often difficult and time-consuming. Although we would like to perceive our decision making processes as rational, we are unable to meet the cognitive and information demands necessary to always reach optimal solutions. Although the demands of rationality exceed the capabilities of human decision makers, we must still strive to make rational decisions. Decision makers use four means to adapt to their limitations: They conduct local rather than comprehensive alternative searches; they evaluate alternatives sequentially rather than simultaneously; they satisfied rather than optimize; and they use judgmental heuristics to reduce the demands of information processing.

Communication is the process by which information is transmitted and *understood* between two or more people. Communication supports work coordination, organizational learning, decision making, and employee wellbeing.

The communication process involves forming, encoding, and transmitting the intended message to a receiver, who then decodes the message and provides feedback to the sender. Effective communication occurs when the sender's thoughts are transmitted to and understood by the intended receiver. To improve this process, both sender and receiver should have common codebooks, share common mental models, be familiar with the message topic, and be proficient with the communication channel. The two main types of communication channels are verbal and nonverbal.

Several barriers create noise in the communication process. People misinterpret messages because of perceptual biases. Some information is filtered out as it gets passed up the hierarchy. Jargon and ambiguous language are barriers when the sender and receiver have different interpretations of the words and symbols used. People also screen out or misinterpret messages due to information overload. These problems are often amplified in cross-cultural settings because of language barriers and differences in meanings of nonverbal cues.

Leadership is defined as the ability to influence, motivate, and enable others to contribute toward the effectiveness and success of the organizations of which they are members. Leaders use influence to motivate followers and arrange the work environment so that they do the job more effectively. Leaders exist throughout the organization, not just in the executive suite. The competency perspective tries to identify the characteristics of effective leaders. Recent writing suggests that leaders have specific personality characteristics, positive self-concept, drive, integrity, leadership, motivation, knowledge of the business, cognitive and practical intelligence, and emotional intelligence. The behavioral perspective of leadership identifies two clusters of leader behavior, people-oriented and task-oriented. People oriented behaviors include showing mutual trust and respect for subordinates, demonstrating a genuine concern for their needs, and having a desire to look out for their welfare. Task-oriented behaviors include assigning employees to specific tasks, clarifying their work duties and procedures, ensuring they follow company rules, and pushing them to reach their performance capacity.

7.7 Unit End Exercise

1. Explain the decision making model
2. Describe the communication process.
3. Explain the communication barriers.
4. Define leadership and its various types.
5. Explain the characteristics of leaders.

7.8 Answers for check your progress

1. Certain environments exist when information is sufficient to predict the results of each alternative in advance of implementation.
2. Routine problems arise on a regular basis and can be addressed through standard responses, called programmed decisions.
3. *Encoding is* the process of translating an idea or thought into a message consisting of verbal, written, or nonverbal symbols (such as gestures), or some combination of them.
4. Nonverbal communication that takes place through facial expressions, body position, eye contact, and other physical gestures is important both to understand and master the concept.
5. *Proxemics*, the study of the way space is utilized, is important to communication.

7.9 Suggested Readings

1. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.
2. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.
3. Sarason and Sarason. (2010). Abnormal Psychology: The Problem of Maladaptive Behaviour (11th Edition). New Delhi. Prentice Hall of India Pvt. Ltd.

UNIT 8

MOOD DISORDER, SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDER

Structure

8.1 Introduction
8.2 Objectives
8.3 Mood disorder
  8.3.1 Depressive disorder
  8.3.2 Causes
  8.3.3 Treatment
8.4 Bipolar disorder
  8.4.1 Causes
  8.4.2 Treatment
8.5 Cyclothymic disorder
8.6 Schizophrenia
  8.6.1 Symptoms
  8.6.2 Causes
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8.7 Other schizophrenic spectrum disorder
  8.7.1 Brief Psychotic disorder
  8.7.2 Schizo affective disorder
  8.7.3 Shared psychotic disorder
8.8 Let's Sum up
8.9 Unit End Exercise
8.10 Answers for check your progress
8.11 Suggested Readings

8.1 INTRODUCTION

Emotion is the important factor in human life. Our behavior mainly depends upon the emotion. We act according to our emotional state.

The problem in emotion causes various abnormal behaviors such as mood disorder, psychotic disorders. These disorders affect individual personal life as well as the community. It creates serious problem to the caregivers.

8.2 Objectives

On completion of this unit, You will be able to understand the following concept

- Depressive disorder
- Bipolar disorder
- Delusional disorder and
- Schizophrenia

8.3 MOOD DISORDER

Mood refers to our emotional state or our prevailing frame of mind. Our mood can significantly affect our perceptions of the world, sense of well-being, and interactions with others. Persistent changes in mood, Two groups of mental disorders involve significant mood changes—depressive and bipolar disorders.

8.3.1 Depressive Disorders

Depressive disorders, a group of related disorders characterized by depressive symptoms, include major depressive disorder, persistent depressive disorder (dysthymia), and premenstrual dysphoric disorder

Diagnosis and Classification of Depressive Disorders

Major depressive disorder (MDD)

According to DSM-5, a major depressive episode involves a consistent pattern of (a) depressed mood, feelings of sadness, or emptiness and/or (b) loss of interest or pleasure in previously enjoyed activities. The individual must *also* experience at least four additional changes in functioning involving: significant alteration in weight or appetite; atypical sleep patterns; restlessness or sluggishness; low energy; feelings of guilt or worthlessness; difficulty concentrating or making decisions; or preoccupation with death or suicide (APA, 2013) Many people experience anxious distress during a depressive episode.

Suicide is a significant concern for anyone with MDD. People who feel hopeless or behave impulsively may act on suicidal thoughts, especially if they are under the influence of drugs or alcohol

Persistent Depressive Disorder (Dysthymia)

Persistent depressive disorder (dysthymia) involves chronic depressive symptoms that are present most of the day for more days than not during a 2-year period (with no more than 2 months symptom-free). According to the DSM-5, dysthymia involves the ongoing presence of at least two of the following symptoms: feelings of hopelessness, low self-esteem, poor appetite or overeating, low energy or fatigue, difficulty concentrating or making decisions, or sleeping too little or too much (APA, 2013)

Premenstrual Dysphoric Disorder

Premenstrual dysphoric disorder (PMDD) is a controversial diagnostic category serious symptoms of depression, irritability, and tension that appear the week before menstruation and disappear soon after menstruation begins

Prevalence of Depressive Disorders

Depression is one of the most common psychiatric disorders and the second leading cause of disability worldwide, affecting approximately 298 million people each year For many people, depression is a chronic disorder. If depressive symptoms do not completely resolve with treatment, the chances of a relapse or chronic depression are greatly increased. The most common lingering symptoms of depression include poor concentration, lack of decisiveness, low energy, and sleep difficulties

8.3.2 Etiology of Depressive Disorders

Biological Dimension

Biological explanations regarding depressive disorders generally focus on neurotransmitters and stress-related hormones, genetic

influences, structural or functional brain irregularities, circadian rhythm disruption, or interactions among these factors.

Neurotransmitters:

Low levels of certain neurotransmitters, including serotonin, norepinephrine, and dopamine, are associated with depression. When our biochemical systems are functioning normally, neurotransmitters regulate our emotions and basic physiological processes involving appetite, sleep, energy, and libido; however, biochemical irregularities can produce the physiological symptoms associated with depression.

The Role of Heredity:

Depression tends to run in families, and the same types of depressive disorders are often found among members of the same family. Studies comparing the prevalence of depressive disorders among the biological and adoptive families of individuals with depression indicate that the incidence is significantly higher among biological relatives compared to adoptive family members.

Cortisol, Stress, and Depression

Dysregulation and over activity of the hypothalamic- pituitary-adrenal (HPA) axis and overproduction of stress-related hormones such as cortisol appear to play an important role in the development of depression. An overactive stress response system and excessive cortisol production may also cause depressive symptoms by depleting certain neurotransmitters, particularly serotonin. Additionally, stress can affect the production of enzymes that are necessary for our brains to use serotonin effectively

Functional and Anatomical Brain Changes with Depression

Neuroimaging studies document decreased brain activity and other brain changes in people with depression (Stahl & Wise, 2008). For example, researchers have found that individuals experiencing depression have increased connectivity in the brain regions referred to as the *default mode network*, regions that are associated with a wakeful resting state.

Psychological Dimension

Behavioral Explanations

Behavioral explanations suggest that depression occurs when people receive insufficient social reinforcement. Losses such as unemployment, divorce, or the death of a friend or family member can reduce available reinforcement (e.g., love, affection, companionship) and produce depression. Consistent with this perspective, behaviorists believe that it is possible to reduce depressive symptoms by becoming more socially active,

Cognitive Explanations

Cognitive psychologists contend that depression is caused by the way people think and that negative thoughts and errors in thinking result in pessimism, damaging self-views, and feelings of helplessness. In other words, depression may result from our internal responses to what is happening around us. Depression is a disturbance in thinking rather than a disturbance in mood, according to some theories

Social Dimension

Stressful interpersonal events can exert a powerful influence on our mood and increase the risk of depression. Severe acute stress (e.g., serious illness or death of a loved one) often precedes the onset of major depression and is much more likely to cause a first depressive episode than is chronic stress. Individuals who fail to develop secure attachments and trusting relationships with caregivers early in life have increased vulnerability to depression when confronted with stressful life events Distressing social interactions are also linked with depression. For example, social rejection increases risk of depression,

Cultural Influences on Depression

A person’s cultural background may influence descriptions of depressive symptoms, decisions about treatment, doctor–patient interactions, and the likelihood of outcomes such as suicide. In some cultures, depression is expressed in the form of somatic or bodily

complaints, rather than as sadness. For example, depression is often experienced as “nerves” and headaches in Latino and Mediterranean cultures; weakness, tiredness, or “imbalance” in Chinese and other Asian cultures; problems of the “heart” in Middle Eastern cultures.

8.3.3 Treatments for Depressive Disorders

Medication

Antidepressant medications increase the availability of certain neurotransmitters in the brain.

Brain Stimulation Therapies

Electroconvulsive therapy, vagus nerve stimulation, and transcranial magnetic stimulation are sometimes used to treat severe or chronic treatment-resistant depression,

Psychological and Behavioral Treatments for Depressive Disorders

Three approaches behavioral activation, interpersonal therapy, and cognitive-behavior therapy.

Behavioral Activation Therapy

Behavioral activation therapy, based on principles of operant conditioning, focuses on helping those who are depressed to increase their participation in enjoyable activities and social interactions. The goal is to have clients improve their mood by actively engaging in life. This emphasis is very important because individuals with depression often lack the motivation to participate in social activities. Behavioral activation therapy is based on the idea that depression results from diminished reinforcement behavioral therapy have received extensive research support for treating depression,

Interpersonal Psychotherapy

Interpersonal psychotherapy is an evidence based treatment focused on current interpersonal problems. Because this approach presumes that depression occurs within an interpersonal context, therapy

focuses on relationship issues. Clients learn to evaluate their role in interpersonal and make positive changes in their relationships.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) focuses on altering the negative thought patterns and distorted thinking associated with depression. Cognitive therapists teach clients to identify thoughts that precede upsetting emotions. **Check Your Progress**

1. What is depressive disorder?
2. What is dysthemia?

8.4 Bipolar Disorder

Introduction

Bipolar disorder is a group of disorders that involve episodes of hypomania and mania that may alternate with episodes of depression. Although depressive symptoms occur in bipolar disorders, depressive disorders and bipolar disorders are very different conditions. First, bipolar disorders have a very strong genetic component. In fact, there is strong evidence of physiological overlap (i.e., shared biological etiology) between bipolar disorders and schizophrenia. Second, people with bipolar disorders respond to medications that have little effect with depressive disorders. Third, the peak age of onset is somewhat earlier for bipolar disorders (teens and early twenties) than for depressive disorders (late twenties). And finally, bipolar disorders occur much less frequently than depressive disorders

Features and Conditions Associated with Bipolar Disorder

Bipolar disorder is associated with various features and comorbid conditions. Mixed features is important to note because when hypomanic /manic symptoms occur with depressive symptoms, the risk of impulsive behaviors such as suicidal actions or substance abuse increases; those who have this pattern often require more intensive treatment.

Rapid cycling, a pattern where there are four or more mood episodes per year, occurs in some individuals with bipolar disorder; this pattern is especially common among those who develop bipolar symptoms at an early age Those with bipolar disorder often have comorbid (concurrent) anxiety disorders (especially panic attacks), attention deficit/hyperactivity disorder, and substance-use. Bipolar disorder is also associated with increased rates of physical illnesses such as hypertension, cardiovascular disease, and diabetes, as well as increased rates of death from suicide Bipolar disorder is also associated with increased rates of physical illnesses such as hypertension, cardiovascular disease, and diabetes, as well as increased rates of death from suicide.

8.4.1 Etiology of Bipolar Disorders

Biological Dimension

Genetic factors contribute to bipolar disorder, a well-established finding from twin, adoption, and family studies. Various neurological abnormalities are associated with bipolar symptoms. For example, irregularities in the way the brain processes and responds to stimuli associated with reward are associated with both manic and depressive symptoms individuals with hypersensitive neurological systems appear to have a vulnerability to bipolar disorder that is triggered by events that activate or deactivate brain systems involved in regulating energy and motivation. It is likely that multiple biochemical pathways contribute to the symptoms associated with bipolar disorder.

Other Etiological Factors Associated with Bipolar Disorders

Psychological and social factors may also influence the development and progression of bipolar disorders. For example, a major stressful event sometimes occurs just prior to the onset of bipolar symptoms. Inadequate social support and strained social relationships are sometimes evident prior to the onset of both manic and depressive symptoms. Rumination is common among individuals with bipolar disorder who experience depression; researchers theorize that rumination results from deficits in both executive functioning and emotional

regulation. Biological factors appear to play a much more prominent role in the development of bipolar disorders compared to other factors.

8.4.2 Treatment for Bipolar Disorders

Biomedical Treatments for Bipolar Disorders

Treatment for bipolar disorders can be complicated. Medications vary depending on a person's present and past symptom. Mood-stabilizing medications such as lithium are the foundation of treatment for bipolar disorder. Although anticonvulsant and antipsychotic medications with mood-stabilizing properties are also used, lithium is considered the most effective mood-stabilizing medication for those who respond to its effects

Psychosocial Treatments for Bipolar Disorders

Psychosocial therapies such as family-focused therapy, interpersonal therapy, and cognitive-behavioral therapy play a key role in helping those with bipolar disorder. Educating families about bipolar disorder and teaching communication and problem-solving skills to all family members is effective in reducing the risk of relapse and hospitalization. Therapists teach clients to avoid stress and overly ambitious goal setting, practice emotional regulation techniques, identify signs of an impending mood episode, and understand the dangers of substance abuse. Mindfulness interventions have proven successful in helping those with bipolar disorder regulate their moods, especially when mindfulness practices are used at the onset of a mood episode.

8.5 Cyclothymic Disorder

Cyclothymic disorder involves impairment in functioning resulting from milder hypomanic symptoms that are consistently interspersed with milder depressed moods for at least 2 years. For this diagnosis, the depressive moods must not reach the level of a major depressive episode and the energized symptoms must not meet the criteria for a hypomanic or manic episode. Additionally, the person must experience mood symptoms at least half of the time and never be symptom-free for more than 2 months. Cyclothymic disorder is similar to persistent depressive

disorder (dysthymia) because the mood symptoms are chronic; however, with cyclothymic disorder there are also periods of hypomanic behavior.

Check your Progress

3. What is Bipolar disorder?

8.6 Schizophrenia spectrum Disorder

Introduction

Individuals with schizophrenia and some of the related disorders we discuss in this chapter lose contact with reality, see or hear things that are not actually present (hallucinations), or develop false beliefs about themselves or others (delusions). Schizophrenia is a serious chronic mental illness on the severe end of the schizophrenia spectrum.

The disorders on the schizophrenia spectrum all involve specific symptoms: psychosis (an impaired sense of reality that frequently involves hallucinations and delusions); impaired cognitive processes (including disorganized speech); unusual or disorganized motor behavior; and a constellation of uncommon behaviors that affect social interactions. schizophrenia spectrum disorders vary in severity, duration of symptoms, causes, and outcome. Schizophrenia is one of the most serious disorders on the spectrum. A diagnosis of schizophrenia in a member of the family affects all members of the unit.

8.6.1 Symptoms of Schizophrenia spectrum

The symptoms associated with schizophrenia spectrum disorders fall into four categories: positive symptoms, psychomotor abnormalities, cognitive symptoms, and negative symptoms.

Positive symptoms associated with schizophrenia spectrum disorders involve delusions, hallucinations, disordered thinking, incoherent communication, and bizarre behavior. These symptoms can range in severity, and persist or fluctuate. Many people with positive symptoms do not understand that their symptoms are the result of mental illness. **Delusions (**false personal beliefs), **persecutory Delusions (**beliefs that others are plotting against them, talking about them, or out to harm),

hallucination (misperception of a nonexistent) are predominant features of schizophrenia spectrum.

Cognitive Symptoms

Disordered thinking, communication, and speech are common characteristics of schizophrenia. Individuals experiencing these symptoms may have difficulty focusing on one topic, speak in an unintelligible manner, or reply tangentially to questions.

Loosening of associations, also referred to as *cognitive slippage*, is another characteristic of disorganized thinking. This involves a continual shifting from topic to topic without any apparent logical or meaningful connection between thoughts. Cognitive symptoms of schizophrenia also include problems with attention and memory and difficulty making decisions.

Abnormal Psychomotor Behavior

catatonia, a condition involving extremes in activity level (either unusually high or unusually low), peculiar body movements or postures, strange gestures and grimaces, or a combination of these silly activities. They may talk and shout constantly, moving or running until they drop from exhaustion. They may appear to be active and display loud, inappropriate laughter. They sleep little and are continually on the go. People experiencing *withdrawn catatonia* are extremely unresponsive, as was the young man in the case study. They show prolonged periods of stupor and mutism, despite an awareness of all that is going on around them.

Negative Symptoms

Negative symptoms of schizophrenia are associated with an inability or decreased ability to initiate actions or speech, express emotions, or feel pleasure. Such symptoms include:

Avolition—an inability to initiate or persist in goal-directed behavior;

Alogia—a lack of meaningful speech;

Asociality—minimal interest in social relationships;

Anhedonia—reduced ability to experience pleasure from positive events; and

Diminished emotional expression—reduced display of emotion involving facial expressions, voice intonation, or gestures in situations in which emotional reactions are expected.

8.6.2 Etiology of Schizophrenia

Biological Dimension

Genetics and heredity play an important role in the development of schizophrenia. Researchers have found that closer blood relatives of individuals diagnosed with schizophrenia run a greater risk of developing the disorder

Neurostructures

Individuals with schizophrenia have decreased volume in the cortex and other areas of the brain, as well as ventricular enlargement. Ventricular enlargement may be an early indication of an increased susceptibility to schizophrenia ineffective communication between different brain regions may lead to the cognitive symptoms (e.g., disorganized speech and impairment in memory, decision making, and problem solving), negative symptoms (e.g., lack of drive or initiative), and positive symptoms (e.g., delusions and hallucinations) that are found in schizophrenia.

Biochemical Influences

Abnormalities in certain neurotransmitters (chemicals that allow brain cells to communicate with one another) including dopamine, serotonin, GABA, and glutamate have also been linked to schizophrenia. According to the dopamine hypothesis, schizophrenia may result from excess dopamine activity in certain areas of the brain.

Psychological Dimension

Individuals who develop schizophrenia have certain cognitive attributes, dysfunctional beliefs, and interpersonal functioning that may predispose them to the development of psychotic symptoms. Communication problems and the lack of insight that frequently occurs with schizophrenia may result, in part, from deficits in the theory of

mind—the ability to recognize that others have emotions, beliefs, and desires that may be different from one's own. Early cognitive deficits are also associated with schizophrenia. Numerous studies have documented an association between early developmental delay and schizophrenia. Certain personal cognitive processes involving misattributions or negative attitudes can lead to or maintain psychotic symptoms such as delusions.

Social Dimension

The role of social relationships in the development of schizophrenia has been extensively s Maltreatment during childhood or other significant social stressors may alter neurodevelopment in a manner that increases susceptibility to schizophrenia. Certain social events appear to influence the appearance of psychotic symptoms. **Expressed emotion (EE)**, a negative communication pattern found among some relatives of individuals with schizophrenia, has been associated with higher relapse rates in individuals diagnosed with schizophrenia. EE is determined by a variety of factors, including critical comments made by relatives; statements of dislike or resentment directed toward the individual with schizophrenia by family members.

Socio cultural Dimension

Cultural Issues with Schizophrenia

Culture may affect how people view or interpret symptoms of schizophrenia. In Japan, for example, schizophrenia is highly stigmatized. The condition was previously called *seishin-bunretsu-byou*, which roughly translates to "a split in mind or spirit," a term that implies it is an irreversible condition.

8.6.3 Treatment of Schizophrenia

Through the years, schizophrenia has been treated by a variety of means, including performing a **prefrontal lobotomy**—a surgical procedure in which the frontal lobes are disconnected from the remainder of the brain. Today schizophrenia is often treated with antipsychotic medication, along with some type of psychosocial therapy

Antipsychotic Medications

First, antipsychotic medication can reduce intensity of symptoms; second, dosage levels should be carefully monitored; and third, side effects can occur as a result of medication and may affect a person's willingness to take prescribed medications.

Many consider the 1955 introduction of *Thorazine*, the first antipsychotic drug, to be the beginning of a new era in treating schizophrenia. For the first time, a medication was available that sufficiently relaxed even those most severely affected by schizophrenia

Psychosocial Therapy

Inpatient Approaches

Both milieu therapy and behavioral therapy can be beneficial for individuals with schizophrenia receiving inpatient treatment. In milieu therapy, the hospital environment operates as a community within which those with schizophrenia exercise a wide range of responsibilities and help make decisions. Psychosocial skills training focuses on increasing appropriate self-care behaviors, conversational skills, and job skills. Undesirable behaviors such as "crazy talk" or social isolation are decreased through reinforcement and modeling techniques

Cognitive-Behavioral Therapy

Major advances have been made in the use of cognitive and behavioral strategies in treating the symptoms of schizophrenia; this is particularly important for those who do not respond to medication. Therapists teach coping skills that allow clients to manage their positive and negative symptoms, as well as the cognitive challenges associated with schizophrenia Cognitive-behavioral treatment to address concerns such as these often includes the following steps

1. Engagement
2. Assessment.
3. Identification of negative
4. Normalization
5. Collaborative analysis of symptoms.
6. Development of alternative explanations.

8.7 Other Schizophrenia Spectrum Disorders

Delusional disorder

Delusional disorder is characterized by persistent delusions that are not accompanied by other unusual or odd behaviors—other than those related to the delusional theme. According to DSM-5, the delusions must persist for at least 1 month (APA, 2013).

Delusional disorder is distinct from the other psychotic disorders due to the absence of additional disturbances in thoughts or perceptions, beyond occasional hallucinations that may be associated with the delusion People with delusional disorder generally behave normally when they are not discussing or reacting to their delusional ideas. Common themes involved in delusional disorders include the following

- *Erotomania*—the belief that someone is in love with the individual; this delusion typically has a romantic rather than sexual focus.
- *Grandiosity*—the conviction that one has great, unrecognized talent, special abilities, or a relationship with an important person or deity.
- *Jealousy*—the conviction that one's spouse or partner is being unfaithful.
- *Persecution*—the belief that one is being conspired or plotted against.
- *Somatic complaints*—convictions of having body odor, being malformed, or being infested by insects or parasites.

Check your Progress

4. **What is catatonia?**
5. **What is Erotomania?**

8.7.1 Brief Psychotic Disorder

A DSM-5 diagnosis of **brief psychotic disorder** requires the presence of one or more psychotic symptoms, including at least one symptom involving delusions, hallucinations, or disorganized speech, that continue for at least 1 day but last less than 1 month. The symptoms

sometimes occur during pregnancy or within 4 weeks of childbirth (APA, 2013). A psychological trauma can also produce the short-term psychotic episodes seen in brief psychotic disorder. For example, among soldiers engaged in combat in Croatia, 20 percent reported hallucinations and delusions. A significant stressor often precedes the onset. Eve experienced a number of stressors before her psychotic episode. She had just lost her best friend to an accident, was struggling with academic demands t of symptoms, although in some cases the precipitating event is not apparent.

8.7.2 Schizoaffective disorder

Schizoaffective disorder is diagnosed when someone demonstrates psychotic symptoms that meet the diagnostic criteria for schizophrenia combined with symptoms of a major depressive or manic episode that continue for the majority of the time the schizophrenic symptoms are present. Additionally, according to DSM-5, the psychotic features must sometimes continue for at least 2 weeks after symptoms of the manic or depressed episode have subsided. Thus, schizoaffective disorder has features of both schizophrenia and a depressive or bipolar disorder Schizoaffective disorder is relatively rare, occurring in only 0.32 percent of the population, and is more prevalent in women. Younger individuals with this disorder tend to have the bipolar subtype whereas older people are more likely to have the depressive subtype. As with schizophrenia, the age of onset is later for women than men. In a twin study, schizoaffective disorder and schizophrenia showed substantial familial overlap. Similar biochemical and brain structure abnormalities have been found in individuals with schizoaffective disorder and schizophrenia

8.7.3 Shared Psychotic Disorder

In a rare form of delusional disorder (shared psychotic delusion), a person who has a close relationship with an individual with delusional or psychotic beliefs comes to accept those beliefs. Shared delusions (sometimes referred to as *folie à deux*) are more prevalent among those who are socially isolated. The pattern generally involves a family member or partner acquiring the delusional belief from the dominant

individual. A decreased ability to obtain corrective feedback, combined with preexisting personality traits of suspiciousness, may increase a person's susceptibility to developing delusional beliefs. For example, hearing impairment in early adolescence is associated with an increased risk of developing delusions. There is a significant genetic relationship between delusional disorder and schizophrenia.

8.7.4 Culture Bound Syndrome

The diagnostic manual attempts to sensitize clinicians to cultural issues by including a glossary of culture-bound syndromes**.** These are patterns of erratic or unusual thinking and behavior that have been identified in diverse societies around the world and do not fit easily into the other diagnostic categories that are listed in the main body of DSM-IV-TR. They are called "culture-bound" because they are considered to be unique to particular societies, particularly in non-Western or developing countries. Their appearance is easily recognized and understood to be a form of abnormal behavior by members of certain cultures, but they do not conform to typical patterns of mental disorders seen in the United States or Europe. Culture bound syndromes have also been called *idioms of distress.* In other words, they represent a manner of expressing negative emotion that is unique to a particular culture and cannot be easily translated or understood in terms of its individual parts.

8.8 Let's sum up

Mood disorders are among the most common psychological disorders, and the risk of developing them is increasing worldwide, particularly in younger people. Two fundamental experiences can contribute either singly or in combination to all specific mood disorders: a major depressive episode and mania. A less severe episode of mania that does not cause impairment in social or occupational functioning is known as a hypomanic episode. An episode of mania coupled with anxiety or depression is known as a dysphoric manic or mixed episode. An individual who suffers from episodes of depression only is said to have a unipolar disorder. An individual who alternates between depression and mania has a bipolar disorder. Cyclothymic disorder is a

milder but more chronic version of bipolar disorder. The causes of mood disorders lie in a complex interaction of biological, psychological, and social factors. From a biological perspective, researchers are particularly interested in the stress hypothesis and the role of neurohormones. Psychological theories of depression focus on learned helplessness, the depressive cognitive schemas, and interpersonal Schizophrenia is characterized by a broad spectrum of cognitive and emotional dysfunctions that include delusions and hallucinations, disorganized speech and behavior, and inappropriate emotions. The symptoms of schizophrenia can be divided into positive, negative, and disorganized. Positive symptoms are active manifestations of abnormal behavior, or an excess or distortion of normal behavior, and include delusions and hallucinations. Negative symptoms involve deficits in normal behavior on such dimensions as affect, speech, and motivation. Disorganized symptoms include rambling speech, erratic behavior, and inappropriate affect. A number of causative factors have been implicated for schizophrenia, including genetic influences, neurotransmitter imbalances, structural damage to the brain caused by a prenatal viral infection or birth injury, and psychological stressors.

8.9 Unit End Exercise

1. Define the term mood disorder and describe the key features of major depressive disorder.
2. Describe the key features of bipolar disorder and cyclothymic disorder.
3. Define the term *schizophrenia.* Evaluate methods used to treat schizophrenia.
4. Describe the general features of other disorders in the schizophrenia spectrum.

8.10 Answers for Check your Progress

1. Depressive disorders, a group of related disorders characterized by depressive symptoms, include major depressive disorder, persistent depressive disorder (dysthymia), and premenstrual dysphoric disorder

2. Persistent depressive disorder (dysthymia) involves chronic depressive symptoms that are present most of the day for more days than not during a 2-year period (with no more than 2 months symptom-free).
3. Bipolar disorder is a group of disorders that involve episodes of hypomania and mania that may alternate with episodes of depression.
4. **catatonia**, a condition involving extremes in activity level (either unusually high or unusually low), peculiar body movements or postures, strange gestures and grimaces, or a combination of these silly activities.
5. *Erotomania means* the belief that someone is in love with the individual; this delusion typically has a romantic rather than sexual focus.

8.11 Suggested Readings

1. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.
2. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.
3. Sarason and Sarason. (2010). Abnormal Psychology: The Problem of Maladaptive Behaviour (11th Edition). New Delhi. Prentice Hall of India Pvt. Ltd.

UNIT 9

DISORDERS OF ADULT PERSONALITY AND BEHAVIOUR

Structure

INTRODUCTION

Adulthood is the crucial stage of human life. Each individual develops his/ her own personality types based on various factors such as childhood experience, Genetic factors, social factors, mental abilities. Sometimes the deprivation on one of these factors causes disorder in personality and leads to maladaptive behavior. The personality and behavior change in adult life is vast one. In this chapter, we are discussing various disorders that impact on adult personality and behavior.

Objectives

By the end of this unit, You will be able to understand

- Eating disorders
- Sleep Disorders
- Personality disorder
- Impulse control disorder
- Sexual and gender identity disorder

EATING DISORDER

Eating disorders are severe disturbances in eating behavior. Some experts suggest that dieting disorder is a more accurate term, because dread of weight gain and obsession with weight loss often are central features of eating disorders. DSM-IV-TR lists two major types of eating disorders: anorexia nervosa and bulimia nervosa. Both anorexia and bulimia are about 10 times more common among females than males, and they develop most commonly among women in their teens and early twenties. The increased incidence among young people reflects both the intense focus on young women's physical appearance and the difficulties

many adolescent girls have in adjusting to the rapid changes in body shape and weight that begin with puberty.

Anorexia nervosa

The most obvious characteristic of anorexia nervosa is extreme emaciation, or more technically, the refusal to maintain a minimally normal body weight. The term anorexia literally means "loss of appetite," but this is a misnomer. People with anorexia nervosa *are* hungry, yet they starve themselves.

Symptoms of Anorexia

Refusal to Maintain a Normal Weight

The most obvious and most dangerous symptom of anorexia is a refusal to maintain a minimally normal body weight. Anorexia nervosa often begins with a diet to lose just a few pounds. The diet goes awry, however, and losing weight eventually becomes the key focus. Weight falls well below the normal range and often plummets to dangerously low levels.

Disturbance in Evaluating Weight or Shape

A second defining symptom of anorexia nervosa can involve one of several related symptoms about weight and shape. Other people with the disorder suffer from *a* disturbance in the way body weight or shape is experienced. Sometimes this may include a distorted body image, an inaccurate perception of body size and shape.

Fear of Gaining Weight

An intense fear of becoming fat is a third defining characteristic of anorexia. The fear of gaining weight presents particular problems for treatment.

Cessation of Menstruation

Amenorrhea, the absence of at least three consecutive menstrual cycles, is the final DSM-IV-TR symptom of anorexia nervosa (in

females). The presence of amenorrhea has led to speculation about the role of sexuality and sexual maturation in causing anorexia nervosa.

Medical Complications

Anorexia nervosa can cause a number of medical complications. People with anorexia commonly complain about constipation, abdominal pain, intolerance to cold, and lethargy. Some of these complaints stem from the effects of semi starvation on blood pressure and body temperature.

Comorbid Psychological Disorders

Anorexia nervosa is associated with other psychological problems, including obsessive–compulsive disorder and obsessive– compulsive personality disorder. People with anorexia nervosa are obsessed with food and diet, and they often follow compulsive eating rituals.

Struggle for Control

Some people with anorexia act impulsively, but clinical accounts and some research suggest that more are conforming and controlling.

Symptoms of Bulimia

Inappropriate Compensatory Behavior

Almost all people with bulimia nervosa engage in purging, designed to eliminate consumed food from the body. The most common form of purging is self-induced vomiting; as many as 90 percent of people with bulimia nervosa engage in this behavior (APA, 2000).

Binge eating

Binge eating is defined as eating an amount of food that is clearly larger than most people would eat under similar circumstances in a fixed period of time, for example, less than two hours. There have been some attempts to define a binge more objectively, such as eating more than 1,000 calories,

Excessive Emphasis on Weight and Shape

People with bulimia nervosa place excessive emphasis on body shape and weight in evaluating themselves, a symptom shared with anorexia nervosa. Their self esteem and much of their daily routine, centers around weight and diet.

Comorbid Psychological Disorders

Depression is common among individuals with bulimia nervosa, especially those who self-induce vomiting (APA, 2000). Other disorders that may co-occur with bulimia nervosa include anxiety disorders, personality disorders (particularly borderline personality disorder), and substance abuse, particularly excessive use of alcohol and or stimulants. Although each of these psychological difficulties presents special challenges in treating bulimia, the co morbidity with depression is most common and most significant.

Medical Complications

A number of medical complications can result from bulimia nervosa. Repeated vomiting can erode dental enamel, particularly on the front teeth, and in severe cases teeth can become chipped and ragged looking. Repeated vomiting can also produce a gag reflex that is triggered too easily and perhaps unintentionally.

Causes of eating disorder

Social Factors

Standards of beauty and the premium placed on young women's appearance contribute to causing eating disorders.

Troubled Family Relationships

Troubled family relationships may also increase vulnerability to the culture of thinness. Young people with bulimia nervosa report considerable conflict and rejection in their families, difficulties that also may contribute to their depression.

Psychological Factors

A Struggle for Perfection and Control

Perfectionism is another part of the endless pursuit of control. Perfectionists set unrealistically high standards, are self-critical, and demand a nearly flawless performance from themselves. Young people with eating disorders may also try to control their own emotions excessively. They may lack interoceptive awareness—recognition of internal cues, including hunger and various emotional states.

Depression, Low Self-Esteem, and Dysphoria

Depression is often comorbid with eating disorders, particularly bulimia nervosa. Depressive symptoms, and not necessarily clinical depression, also may play a role in eating disorders. Low self-esteem is a particular concern. In particular, women with eating disorders may be preoccupied with their *social self*, how they present themselves in public.

Negative Body Image

A negative body image, a highly critical evaluation of one's weight and shape.

Dietary Restraint

Some symptoms of eating disorders may be effects of dietary restraint, that is, direct consequences of overly restrictive eating contribute to the development of eating disorder.

Biological Factors

Physiologically, weight is maintained around weight set points, fixed weights or small ranges of weight. Weight regulation around set points results from the interplay between behavior (e.g., exercise, eating), peripheral physiological activity (e.g., digestion, metabolism), and central physiological activity. Genetic factors also contribute to eating disorders. An early twin study of bulimia nervosa found a concordance rate of 23 percent for MZ twins and 9 percent for DZ twins. Several neurophysiologic measures also are correlated with eating disorders, including elevations in endogenous opioids, low levels of serotonin, and diminished neuroendocrine functioning

Treatment of Anorexia Nervosa

The treatment of anorexia nervosa usually focuses on two goals. The first is to help the patient gain at least a minimal amount of weight. If weight loss is severe, the patient may be treated in an inpatient setting. Hospitalized patients may receive forced or intravenous feeding, The second goal in treating anorexia nervosa is to address the broader eating difficulties. The most carefully studied family therapy is the Maudsley method (named after Maudsley Hospital in London where the treatment was developed). In the Maudsley method, parents take complete control over the anorexic child's eating, planning meals, preparing food, and monitoring eating.

Treatment of Bulimia nervosa

Cognitive Behavior Therapy

First, the therapist uses education and behavioral strategies to normalize eating patterns. The goal is to end the cycle where extreme dietary restraint leads to binge eating and, in turn, to purging. Second, the therapist addresses the client's broader, dysfunctional beliefs about self, appearance, and dieting. Techniques include a variation of Beck's cognitive therapy to address perfectionism or depression. Individual problems such as poor impulse control or troubled relationships also may be addressed at this stage. Third, the therapist attempts to consolidate gains and prepare the client for expected relapses in the future.

Interpersonal Psychotherapy

Interpersonal psychotherapy also can be an effective treatment for bulimia nervosa. This is surprising because interpersonal therapy does not address eating disorders directly but instead focuses on difficulties in close relationships. First, the interpersonal treatments explicitly excluded direct discussions of eating, diet, and related topics. Second, the investigators had lower expectations for interpersonal therapy, and the allegiance effect often influences treatment outcome.

Antidepressant Medications

All classes of antidepressant medications are somewhat effective in treating bulimia nervosa; however, medication alone is *not* the treatment of choice. Binge eating and compensatory behavior improve only among a minority of people treated with antidepressants, and relapse is common when medication is stopped.

Check Your Progress

1. What is Anorexia nervosa?
2. What is Bulimia nervosa?

9.4 SLEEP DISORDER

INTRODCTION

We spend about one third of our lives asleep. That means most of us sleep nearly 3,000 hours per *year*. For many of us, sleep is energizing, both mentally and physically. Unfortunately, most people do not get enough sleep, and 28% of people in the United States report feeling excessively sleepy during the day. Most of us know what it's like to have a bad night's sleep. The next day we're a little groggy, and as the day wears on we may become irritable. Research tells us that even minor sleep deprivation over only 24 hours impedes our ability to think clearly Lack of sleep also affects you physically. People who do not get enough sleep are more susceptible to illnesses such as the common cold, perhaps because immune system functioning is reduced with the loss of even a few hours of sleep.

An Overview of Sleep Disorders

The study of sleep has long influenced concepts of abnormal psychology the relationship between sleep disturbances and mental health is more complex. Sleep problems may cause the difficulties people experience in everyday life, or they may result from some disturbance common to a psychological disorder.

The region of the brain is also involved with our dream sleep, which is called rapid eye movement (REM) sleep**.** Mutual neurobiological connection suggests that anxiety and sleep may be interrelated in important ways, although the exact nature of the

relationship is still unknown. Similarly, REM sleep seems related Sleep disorders are divided into two major categories: **dyssomnias** and **parasomnias. Dys**ssomnias involve difficulties in getting enough sleep, problems with sleeping when you want to and complaints about the quality of sleep, such as not feeling refreshed even though you have slept the whole night. Parasomnias are characterized by abnormal behavioral or physiological events that occur during sleep, such as nightmares and sleepwalking.

9.4.1 Primary Insomnia

Insomnia is one of the most common sleep disorders. Despite the common use of the term *insomnia* to mean "not sleeping," it actually applies to a number of complaints. People are considered to have insomnia if they have trouble falling asleep at night (difficulty initiating sleep), if they wake up frequently or too early and can't go back to sleep (difficulty maintaining sleep), or even if they sleep a reasonable number of hours but are still not rested the next day (non restorative sleep).

Causes

Insomnia accompanies many medical and psychological disorders, including pain and physical discomfort, physical inactivity during the day, and respiratory problems. Sometimes insomnia is related to problems with the biological clock and its control of temperature. Some people who can't fall asleep at night may have a delayed temperature rhythm: Their body temperature doesn't drop and they don't become drowsy until later at n Among the other factors that can interfere with sleeping are drug use and a variety of environmental influences such as changes in light, noise, or temperature.. Finally, various psychological stresses can also disrupt your sleep. For example, one study looked at how medical and dental school students were affected by a particularly stressful event Biological vulnerability may, in turn, interact with *sleep stress*, which includes a number of events that can negatively affect sleep. For example, poor bedtime habits (such as having too much alcohol or caffeine) can interfere with falling asleep. Note that biological vulnerability and sleep stress influence each other.

9.4.2 Primary Hypersomnia

Insomnia involves not getting enough sleep (the prefix *in* means "lacking" or "without"), and **hypersomnia** is a problem of sleeping too much (*hyper* means "in great amount" or "abnormal excess"). Many people who sleep all night find themselves also falling asleep several times in next day. Several factors that can cause excessive sleepiness would not be considered hypersomnia. People with hypersomnia sleep through the night and appear rested upon awakening but still complain of being excessively tired throughout the day. Another sleep problem that can cause a similar excessive sleepiness is a breathing-related sleep disorder called **sleep apnea**. People with this problem have difficulty breathing at night. They often snore loudly, pause between breaths, and wake in the morning with a dry mouth and headache.

9.4.3 Narcolepsy

Narcolepsy is a different form of the sleeping problem. In addition to daytime sleepiness, people with narcolepsy experience *cataplexy,* a sudden loss of muscle tone. Cataplexy occurs while the person is awake and can range from slight weakness in the facial muscles to complete physical collapse. Cataplexy lasts from several seconds to several minutes; it is usually preceded by strong emotion such as anger or happiness. Imagine that while cheering for your favorite team, you suddenly fall asleep; while arguing with a friend, you collapse to the floor in a sound sleep. Cataplexy appears to result from a sudden onset of REM sleep. Instead of falling asleep normally and going through the four non-rapid eye movement (NREM) stages that typically precede REM sleep, people with narcolepsy periodically progress right to this dream-sleep stage almost directly from the state of being awake.

9.4.4 Treatment for Sleep Disorder

Medical Treatments

People who complain of insomnia to a medical professional are likely prescribed one of several benzodiazepine or related medications, which include short-acting drugs and long-acting drugs such as. Short-

acting drugs (those that cause only brief drowsiness) are preferred because the long-acting drugs sometimes do not stop working by morning and people report more daytime sleepiness

Environmental Treatments

One general principle for treating circadian rhythm disorders is that phase delays (moving bedtime later) are easier than phase advances (moving bedtime earlier). In other words, it is easier to stay up several hours later than usual than to force yourself to go to sleep several hours earlier. Scheduling shift changes in a clockwise direction (going from day to evening schedule) seems to help workers adjust better. Another strategy to help people with sleep problems involves using bright light to trick the brain into readjusting the biological clock.

Psychological Treatments

Different treatments help people with different kinds of sleep problems. For example, relaxation treatments reduce the physical tension that seems to prevent some people from falling asleep at night. Some people report that their anxiety about work, relationships, or other situations prevents them from sleeping or wakes them up in the middle of the night. To address this problem, cognitive treatments are used. Research shows that some psychological treatments for insomnia may be more effective than others. For adult sleep problems, stimulus control may be recommended. People are instructed to use the bedroom only for sleeping and for sex and *not* for work or other anxiety-provoking activities (for example, watching the news on television).

Parasomnias

Parasomnias are not problems with sleep itself but abnormal events that occur either during sleep or during that twilight time between sleeping and waking. Some events associated with parasomnia are not unusual if they happen while you are awake (e.g., walking to the kitchen to look into the refrigerator) but can be distressing if they take place while you are sleeping.

Parasomnias are of two types: those that occur during REM sleep, and those that occur during NREM sleep. Nightmares occur during REM or dream sleep. Sleep terrors, which most commonly afflict children, usually begin with a piercing scream. The child is extremely upset, often sweating, and frequently has a rapid heartbeat. On the surface, sleep terrors appear to resemble nightmares— the child cries and appears frightened—but they occur during NREM sleep. Sleepwalking (also called somnambulism) occurs during NREM sleep. This means that when people walk in their sleep, they are probably not acting out a dream. This parasomnia typically occurs during the first few hours while a person is in the deep stages of sleep.

Check Your Progress

3. What is somnambulism? 4. What is Narcolepsy?

9.5 PERSONALITY DISORDER

Introduction

The *DSM-IV-TR* definition notes that these personality characteristics are “inflexible and maladaptive and cause significant functional impairment or subjective distress.” personality disorders are chronic; they do not come and go but originate in childhood and continue throughout adulthood. Because they affect personality, these chronic problems pervade every aspect of a person’s life. For example, if a woman is overly suspicious (a sign of a possible paranoid personality disorder), this trait will affect almost everything she does, including her employment (she may have to change jobs often if she believes coworkers conspire against her), her relationships (she may not be able to sustain a lasting relationship if she can’t trust anyone), and even where she lives (she may have to move often if she suspects her landlord is out to get her). However, individuals with personality disorders may not feel any subjective distress; indeed, it may be others who acutely feel distress because of the actions of the person with the disorder.

Personality Disorder Clusters

DSM-IV-TR divides the personality disorders into three groups, or clusters (see Table 11.1) (American Psychiatric Association, 2000). The cluster division is based on resemblance. Cluster A is called the odd or eccentric cluster; it includes paranoid, schizoid, and schizotypal personality disorders. Cluster B is the dramatic, emotional, or erratic cluster; it consists of antisocial, borderline, histrionic, and narcissistic personality disorders. Cluster C is the anxious or fearful cluster; it includes avoidant, dependent, and obsessive-compulsive personality disorders.

9.5.1 Cluster A Personality Disorder

Three personality disorders—paranoid, schizoid, and schizotypal—share common features that resemble some of the psychotic symptoms seen in schizophrenia.

Paranoid Personality Disorder

People with paranoid personality disorder are excessively mistrustful and suspicious of others, without any justification. They assume other people are out to harm or trick them; therefore, they tend not to confide in others. Suspicion and mistrust can show themselves in a number of ways. People with paranoid personality disorder may be argumentative, may complain, or may be quiet. This style of interaction is communicated, sometimes nonverbally, to others, often resulting in discomfort among those who come in contact with them because of this volatility.

Causes

Evidence for biological contributions to paranoid personality disorder is limited. Some research suggests the disorder may be slightly more common among the relatives of people who have schizophrenia, although the association does not seem to be strong. As you will see later with the other odd or eccentric personality disorders in Cluster A, there seems to be some relationship with schizophrenia, although its exact nature is not yet clear. Cultural factors have also been implicated in paranoid personality disorder. Certain groups of people, such as prisoners, refugees, people with hearing impairments, and older adults,

are thought to be particularly susceptible because of their unique experiences

Treatment

Therapists try to provide an atmosphere conducive to developing a sense of trust. They often use cognitive therapy to counter the person's mistaken assumptions about others, focusing on changing the person's beliefs that all people are malevolent and most people cannot be trusted

Schizoid personality disorder

People with this personality disorder show a pattern of detachment from social relationships and a limited range of emotions in interpersonal situations. They seem aloof, cold, and indifferent to other people.

Causes and Treatment

Childhood shyness is reported as a precursor to later adult schizoid personality disorder. It may be that this personality the development of this disorder. Abuse and neglect in childhood are also reported among individuals with this disorder trait is inherited and serves as an important determinant in early problems with interpersonal relationships to produce the social deficits that define schizoid personality disorder. Therapists often begin treatment by pointing out the value in social relationships. The person with the disorder may even need to be taught the emotions felt by others to learn empathy. Because their social skills were never established or have atrophied through lack of use, people with schizoid personality disorder often receive social skills training.

Schizotypal Personality Disorder

People with schizotypal personality disorder are typically socially isolated, like those with schizoid personality disorder.
In addition, they also behave in ways that would seem unusual to many of us, and they tend to be suspicious and have odd beliefs. Schizotypal personality disorder is considered by some to be on a continuum.

Causes

Schizotypal personality disorder is viewed by some to be one phenotype of a schizophrenia genotype. Recall that a phenotype is one way a person's genetics is expressed. A genotype is the gene or genes that make up a particular disorder. However, depending on a variety of other influences, the way you turn out—your phenotype—may vary from other people with a similar genetic makeup. Many characteristics of schizotypal personality disorder, including ideas of reference, illusions, and paranoid thinking, are similar but milder forms of behaviors observed among people with schizophrenia. Genetic research also seems to support a relationship. Some research suggests that schizotypal symptoms are strongly associated with childhood maltreatment among men and this childhood maltreatment seems to result in posttraumatic stress disorder (PTSD) symptoms among women. Cognitive assessment of people with this disorder points to mild to moderate decrements in their ability to perform on tests involving memory and learning,

9.5.2 Cluster B Personality Disorder

Personality Disorders Characterized by Dramatic, Emotional, or Erratic Behavior

This cluster of personality disorders includes the antisocial, borderline, histrionic, and narcissistic types. People with these disorders exhibit behavior patterns that are excessive, unpredictable, or self centered; they also have difficulty forming and maintaining relationships and show antisocial behavior.

Antisocial Personality Disorder

People with antisocial personality disorder are *antisocial* in the sense that they often violate the rights of others, disregard social norms and conventions, and, in some cases, break the law. They show a lack of concern or callous indifference about violating the rights of others and using other people for their own gain. Clinicians once used terms such as *psychopath* and *sociopath* to refer to people who today are classified as having antisocial personalities—people whose behavior is amoral, asocial, and impulsive, and who lack remorse and shame. Antisocial

personality disorder occurs more commonly in men than in women. Over time, antisocial and criminal behavior associated with the disorder tends to decline with age and may disappear by the time the person reaches the age of 40.

Socio-cultural Factors and Antisocial Personality Disorder
Antisocial personality disorder cuts across all racial and ethnic groups. The disorder is most common, however, among people in lower socioeconomic groups. One explanation is that people with antisocial personality disorder drift downward occupationally, perhaps because their antisocial behavior makes it difficult for them to hold steady jobs or to progress upward.

Borderline Personality Disorder

Borderline personality disorder (BPD) is characterized by features such as a deep sense of emptiness, an unstable self-image, a history of turbulent and unstable relationships, dramatic mood changes, impulsivity, difficulty regulating negative emotions, self-injurious behavior, and recurrent suicidal behaviors.

People with borderline personality disorder tend to be uncertain about their personal identities—their values, goals, careers, perhaps even their sexual orientations. This instability in self-image or personal identity leaves them with nagging feelings of emptiness and boredom. They cannot tolerate being alone and make desperate attempts to avoid feelings of abandonment. Borderline personality disorder is usually diagnosed in early adulthood, although signs of the disorder are often seen in adolescence

Histrionic Personality Disorder

Histrionic personality disorder is characterized by excessive emotionality and an overwhelming need to be the center of attention. The term is derived from the Latin *histrio*, which means “actor.” People with histrionic personality disorder tend to be dramatic and emotional, but their emotions seem shallow, exaggerated, and volatile. The disorder was formerly called hysterical personality. People with histrionic personalities may become unusually upset by news of a sad event and

exude exaggerated delight at a pleasant occurrence. They may faint at the sight of blood or blush at a slight faux pas. They tend to demand that others meet their needs for attention and play the victim when others fall short. They also tend to be self-centered and intolerant of delays of gratification: People with histrionic personalities may be attracted to professions like modeling or acting, where they can hog the spotlight.

Narcissistic Personality Disorder

People with narcissistic personality disorder have an inflated or grandiose sense of themselves and an extreme need for admiration. They brag about their accomplishments and expect others to shower them with praise. They expect others to notice their special qualities, even when their accomplishments are ordinary, and they enjoy basking in the light of adulation. They are self-absorbed and lack empathy for others. Although more than half of the people diagnosed with narcissistic personality disorder are men, we cannot say whether there is an underlying gender difference in prevalence rates in the general population.

A certain degree of narcissism may represent a healthful adjustment to insecurity, a shield from criticism and failure, or a motive for achievement. People with narcissistic personalities tend to be preoccupied with fantasies of success and power, ideal love, or recognition for brilliance or beauty. Like people with histrionic personalities, they may gravitate toward careers in modeling, acting, or politics. Interpersonal relationships are invariably strained by the demands that people with narcissistic personality impose on others and by their lack of empathy with, and concern for, other people.

9.5.3 Cluster C Personality Disorder

Personality Disorders Characterized by Anxious or Fearful Behavior

This cluster of personality disorders includes the avoidant, dependent, and obsessive– compulsive types. Although the features of these disorders differ, they share a component of fear or anxiety.

Avoidant Personality Disorder

People with avoidant personality disorder are so terrified of rejection and criticism that they are generally unwilling to enter into relationships without ardent reassurances of acceptance. As a result, they may have few close relationships outside their immediate families. They also tend to avoid group occupational or recreational activities for fear of rejection. They prefer to lunch alone at their desks. Unlike people with schizoid qualities, with whom they share the feature of social withdrawal, individuals with avoidant personalities have interest in, and feelings of warmth toward, other people. However, fear of rejection prevents them from striving to meet their needs for affection and acceptance. In social situations, they tend to hug the walls and avoid conversing with others. They fear public embarrassment, the thought that others might see them blush, cry, or act nervously.

Dependent Personality Disorder

Dependent personality disorder describes people who have an excessive need to be taken care of by others. This leads them to be overly submissive and clinging in their relationships and extremely fearful of separation. People with this disorder find it very difficult to do things on their own. They seek advice in making even the smallest decision. Dependent personality disorder is linked to other psychological disorders, including mood disorders and social phobia, as well as to physical problems such as hypertension, cardiovascular disorder, and gastrointestinal disorders like ulcers and colitis.

Obsessive–Compulsive Personality Disorder

The defining features of obsessive–compulsive personality disorder include excessive orderliness, perfectionism, rigidity, difficulty coping with ambiguity, difficulty expressing feelings, and meticulousness in work habits. Estimates of the prevalence of the disorder vary from 2.1% to 7.9% of the population (APA, 2013). The disorder is about twice as common in men as in women. Unlike obsessive–compulsive anxiety disorder, people with obsessive–compulsive personality disorder do not necessarily experience outright obsessions or compulsions. If they do, both diagnoses may be deemed

appropriate. People with obsessive–compulsive personality disorder are so preoccupied with the need for perfection that they cannot complete work on time.

9.5.4 Causes for Personality Disorder

Biological Perspectives

Genetic Factors Evidence points to genetic factors playing a role in the development of several types of personality disorders, including antisocial, narcissistic, paranoid, and borderline types. Parents and siblings of people with personality disorders, such as antisocial, schizotypal, and borderline types, are more likely to be diagnosed with these disorders themselves than are members of the general population.

Investigators also report finding genetic indicators in a particular chromosome linking to features of borderline personality disorder. Although we have evidence of genetic contributions to personality traits associated with personality disorders, it is important to recognize that environmental factors also play an important contributing role. For example, exposure to environmental influences, such as being raised in a dysfunctional or troubled family, may predispose individuals to develop personality disorders, such as antisocial or borderline personality disorders.

Brain Abnormalities: Brain imaging links borderline personality disorder and antisocial personality disorder to dysfunctions in parts of the brain involved in regulating emotions and restraining impulsive behaviors, especially aggressive behaviors. Areas of the brain most directly implicated are the *prefrontal cortex* (located in the front or anterior part of the frontal lobes) and deeper brain structures in the limbic system. The prefrontal cortex is involved in controlling impulsive behavior, weighing consequences of actions, and solving problems.

Socio-cultural Perspectives

Social conditions may contribute to the development of personality disorders. Because antisocial personality disorder is reported most frequently among people from lower socioeconomic classes, the kinds of stressors encountered by disadvantaged families may contribute to

antisocial behavior patterns. Many inner-city neighborhoods are beset with social problems such as alcohol and drug abuse, teenage pregnancy, and disorganized and disintegrating families. These stressors are associated with an increased likelihood of child abuse and neglect, which may in turn contribute to lower self-esteem and breed feelings of anger and resentment in children. Children reared in poverty are also more likely to be exposed to deviant role models, such as neighborhood drug dealers. Maladjustment in school may lead to alienation and frustration with the larger society, leading to antisocial behavior. Addressing

9.5.5 Treatment

Psychodynamic Approaches

Psychodynamic approaches are often used to help people diagnosed with personality disorders become aware of the roots of their self-defeating behavior patterns and learn more adaptive ways of relating to others. However, people with personality disorders, especially those with borderline and narcissistic personality disorders, often present particular challenges to the therapist. For example, people with borderline personality disorder tend to have turbulent relationships with therapists, sometimes idealizing them, sometimes denouncing them as uncaring.

Promising results are reported using structured forms of psycho dynamically oriented therapies in treating personality disorders. These therapies raise clients' awareness of how their behaviors cause problems in their close relationships. The therapist takes a more direct, confrontational approach that addresses the client's defenses than would be the case in traditional psychoanalysis.

Cognitive-Behavioral Approaches

Cognitive behavior therapists focus on changing clients' maladaptive behaviors and dysfunctional thought patterns rather than their personality structures. They may use behavioral techniques such as modeling and reinforcement to help clients develop more adaptive behaviors. For example, when clients are taught behaviors that are likely to be reinforced by other people, the new behaviors may well be maintained.

Biological Approaches

Drug therapy does not directly treat personality disorders. However, antidepressant and anti-anxiety drugs are sometimes used to treat depression and anxiety in people with personality disorders. Neurotransmitter activity is also implicated in aggressive behavior of the type seen in individuals with borderline personality disorder. The neurotransmitter serotonin helps put the brakes on impulsive behaviors, including acts of impulsive aggression.

9.6 IMPULSE CONTROL DISORDERS

People with borderline personalities often have difficulty controlling their impulses. But problems with impulse control are not limited to people with personality disorders. The *DSM* includes a category of mental disorders called impulse-control disorders that are characterized by difficulties in controlling or restraining impulsive behavior. Impulse-control disorders in *DSM-5* are grouped in a broader category of disruptive, impulse-control, and conduct disorders. Other impulse control problems such as compulsive Internet use and compulsive shopping are presently under consideration for inclusion in later versions of the diagnostic manual. Our focus here is on three types of impulse control disorders: kleptomania, intermittent explosive disorder, and pyromania.

9.6.1 Kleptomania

Kleptomania, which derives from the Greek *kleptes*, meaning thief, and *mania*, meaning “madness” or “frenzy,” is characterized by repeated acts of compulsive stealing. The stolen objects are typically of little value or use to the person. The person may give them away, return them secretly, discard them, or just keep them hidden at home. In most cases, people with kleptomania can easily afford the items they steal. Even wealthy people have been known to be compulsive shoplifters.

9.6.2 Intermittent Explosive Disorder

People have been concerned about the human capacity for rage and the violent behavior it often provokes for time immemorial. Rage is not a criterion used to diagnose mental or psychological disorders in the

DSM. But rage is often a feature of intermittent explosive disorder, or IED, a type of impulse-control disorder characterized by repeated episodes of impulsive, uncontrollable aggression in which people strike out at others or destroy property. The core feature of IED is impulsive aggression, the tendency to lose control of aggressive impulses. People with IED have episodes of violent rage in which they suddenly lose control and hit or try to hit other people or smash objects. Recent research on IED has largely focused on its biological underpinnings, and particularly on the possible role of the neurotransmitter serotonin.

9.6.3 Pyromania

Pyromania, from the Latin roots p*yr*, meaning "fire" and the Greek word *mania*, meaning "madness" or "frenzy," is characterized by repeated acts of compulsive fire setting in response to irresistible urges. Only a small percentage of arsonists are diagnosed with pyromania. The most common motives for fire setting appear to be anger and revenge, Pyromania is considered a rare disorder, which may help explain why it remains so poorly understood. People with pyromania feel a sense of release or psychological relief when setting fires and perhaps feelings of empowerment as the result of prompting firefighters to rush to the scene of the blaze, along with the heavy firefighting equipment they bring. The fire setter may also experience pleasurable excitement by watching or even participating in the firefighting effort.

Check Your Progress

5. What is dependent personality disorder?
6. What is kleptomania?

9.7 SEXUAL AND GENDER IDENTITY DISORDER

Sexual Dysfunctions

Sexual dysfunctions, disorders in which people cannot respond normally in key areas of sexual functioning, Sexual dysfunctions are typically very distressing, and they often lead to sexual frustration, guilt, loss of self-esteem, and interpersonal problems. Often these dysfunctions are interrelated; many patients with one dysfunction experience another as well. The human sexual response can be described

as a *cycle* with four phases: *desire, excitement, orgasm,* and *resolution*. Sexual dysfunctions affect one or more of the first three phases. Resolution consists simply of the relaxation and reduction in arousal that follow orgasm.

9.7.1 Disorders of Desire

The desire phase of the sexual response cycle consists of an urge to have sex, sexual fantasies, and sexual attraction to others. Two dysfunctions—hypoactive sexual desire disorder and sexual aversion disorder—affect the desire phase. People with hypoactive sexual desire disorder lack interest in sex and, in turn, display little sexual activity. Nevertheless, when these individuals do have sex, their physical responses may be normal and they may enjoy the experience.
People with sexual aversion disorder find sex distinctly unpleasant or repulsive. Sexual advances may sicken, disgust, or frighten them. Some people are repelled by a particular aspect of sex,

Causes

A person's sex drive is determined by a combination of biological, psychological, and socio-cultural factors, and any of them may reduce sexual desire.

Biological Causes

A number of hormones interact to help produce sexual desire and behavior, and abnormalities in their activity can lower the sex drive. In both men and women, a high level of the hormone *prolactin,* a low level of the male sex hormone *testosterone,* and either a high or low level of the female sex hormone *estrogen* can lead to low sex drive. Clinical practice and research have further indicated that sex drive can be lowered by certain pain medications, psychotropic drugs, and illegal drugs

Psychological Causes

A general increase in anxiety, depression, or anger may reduce sexual desire in both men and women. Frequently, as cognitive theorists

have noted, people with hypoactive sexual desire and sexual aversion have particular attitudes, fears, or memories that contribute to their dysfunction, such as a belief that sex is immoral or dangerous.

Socio-cultural Causes

The attitudes, fears, and psychological disorders that contribute to hypoactive sexual desire and sexual aversion occur within a social context, and thus certain socio-cultural factors have also been linked to these dysfunctions. Many sufferers are feeling situational pressures—divorce, a death in the family, job stress, infertility difficulties, having a baby. Others may be having problems in their relationships.

9.7.2 Disorders of Excitement

The excitement phase of the sexual response cycle is marked by changes in the pelvic region, general physical arousal, and increases in heart rate, muscle tension, blood pressure, and rate of breathing. In men, blood pools in the pelvis and leads to erection of the penis; in women, this phase produces swelling of the clitoris and labia, as well as lubrication of the vagina.

Female Sexual Arousal Disorder

Women with a female sexual arousal disorder are persistently unable to attain or maintain proper lubrication or genital swelling during sexual activity. Understandably, many of them also experience an orgasmic disorder or other sexual dysfunction.

Male Erectile Disorder

Men with male erectile disorder persistently fail to attain or maintain an adequate erection during sexual activity. This problem occurs in as much as 10 percent of the general male population.

Biological Causes

The same hormonal imbalances that can cause hypoactive sexual desire can also produce erectile disorder. Medical procedures, including ultrasound recordings and blood tests, have been developed for diagnosing biological causes of erectile disorder. Measuring nocturnal penile tumescence (NPT), or erections during sleep, is particularly useful in assessing whether physical factors are responsible.

Psychological Causes

Any of the psychological causes of hypoactive sexual desire can also interfere with arousal and lead to erectile disorder. The cognitive-behavioral theory developed by William Masters and Virginia. The explanation emphasizes performance anxiety and the spectator role. Once a man begins to experience erectile problems, for whatever reason, he becomes fearful about failing to have an erection and worries during each sexual encounter.

Socio-cultural Causes

Each of the socio-cultural factors that contribute to hypoactive sexual desire has also been tied to erectile disorder. Men who have lost their jobs and are under financial stress are suffering with this.

9.7.3 Disorders of Orgasm

During the orgasm phase of the sexual response cycle, an individual's sexual pleasure peaks and sexual tension is released as the muscles in the pelvic region contract, or draw together, rhythmically. The man's semen is ejaculated, and the outer third of the woman's vaginal wall contracts. Dysfunctions of this phase of the sexual response cycle are rapid, or premature, ejaculation; male orgasmic disorder; and female orgasmic disorder.

Rapid, or Premature, Ejaculation

A man suffering from rapid, or premature, ejaculation persistently reaches orgasm and ejaculates with very little sexual stimulation before, on, or shortly after penetration and before he wishes to. Psychological, particularly behavioral, explanations of rapid ejaculation have received more research support than other kinds of explanations. Rapid ejaculation often occurs when a young man has his first sexual encounter. With continued sexual experience, most men acquire greater control over their sexual responses.

Three biological theories have emerged from the limited investigations done so far. One theory states that some men are born with a genetic predisposition to develop this dysfunction. Indeed, one study found that 91 percent of a small sample of men suffering from

rapid ejaculation had first-degree relatives who also displayed the dysfunction. A second theory, based on animal studies, argues that the brains of men with rapid ejaculation contain certain serotonin receptors that are overactive and others that are underactive. A third explanation holds that men with this dysfunction experience greater sensitivity or nerve conduction in the area of their penis, a notion that has received inconsistent research support thus far.

Male Orgasmic Disorder

A man with male orgasmic disorder is repeatedly unable to reach orgasm or is very delayed in reaching orgasm after normal sexual excitement. The disorder occurs in 8 percent of the male population A low testosterone level, certain neurological diseases, and some head or spinal cord injuries can interfere with ejaculation. The drugs which affect the sympathetic nervous system (such as alcohol, some medications for high blood pressure, and certain psychotropic medications) can also affect ejaculation. For example, certain serotonin-enhancing antidepressant drugs appear to interfere with ejaculation in at least 30 percent of men who take them. A leading psychological cause of male orgasmic disorder appears to be performance anxiety and the spectator role, the cognitive-behavioral factors also involved in male erectile disorder

Female Orgasmic Disorder

Women with female orgasmic disorder rarely reach orgasm or generally experience a very delayed one. As many as 24 percent of women apparently have this problem to some degree.

Biological Causes

A variety of physiological conditions can affect a woman's arousal and orgasm. Diabetes can damage the nervous system in ways that interfere with arousal, lubrication of the vagina, and orgasm. Lack of orgasm has sometimes been linked to multiple sclerosis and other neurological diseases,

Psychological Causes

The psychological causes of hypoactive sexual desire and sexual aversion, including depression, may also lead to the female arousal and

orgasmic disorders. In addition, as both psychodynamic and cognitive theorists might predict, memories of childhood traumas and relationships have sometimes been associated with these disorders.

9.7.4 Disorders of Sexual Pain

Two sexual dysfunctions do not fit neatly into a specific phase of the sexual response cycle. These are the sexual pain disorders, *vaginismus* and *dyspareunia,* each marked by enormous physical discomfort when sexual activity is attempted.

Vaginismus

In vaginismus, involuntary contractions of the muscles around the outer third of the vagina prevent entry of the penis. Severe cases can prevent a couple from ever having intercourse. Some women experience painful intercourse because of an infection of the vagina or urinary tract, a gynecological disease such as herpes simplex, or the physical effects of menopause. In such cases vaginismus can be overcome only if the women receive medical treatment for these conditions

Dyspareunia

A person with dyspareunia (from Latin words meaning "painful mating") experiences severe pain in the genitals during sexual activity. Dyspareunia in women usually has a physical cause. Among the most common is an injury (for example, to the vagina or pelvic ligaments) during childbirth. Similarly, the scar left by an episiotomy (a cut often made to enlarge the vaginal entrance and ease delivery) can cause pain.

Paraphilias

Paraphilias are disorders in which individuals repeatedly have intense sexual urges or fantasies or display sexual behaviors that involve nonhuman objects, children, non consenting adults, or the experience of suffering or humiliation. Many people with a paraphilia can become aroused only when a paraphilic stimulus is present, fantasized about, or acted out.

Fetishism

Key features of fetishism are recurrent intense sexual urges, sexually arousing fantasies, or behaviors that involve the use of a nonliving object, often to the exclusion of all other stimuli. Usually the disorder, which is far more common in men than in women, begins in

adolescence. Almost anything can be a fetish; women's underwear, shoes, and boots are particularly common (APA, 2000).

Transvestic Fetishism

Transvestic fetishism, also known as transvestism or cross-dress**ing**, is a recurrent need or desire to dress in clothes of the opposite sex in order to achieve sexual arousal.

Exhibitionism

A person with exhibitionism has recurrent urges to expose his genitals to another person, almost always a member of the opposite sex, or has sexually arousing fantasies of doing so. He may also carry out those urges but rarely attempts to initiate sexual activity with the person to whom he exposes himself (APA, 2000).

Voyeurism

A person who engages in voyeurism has recurrent and intense urges to secretly observe unsuspecting people as they undress or to spy on couples having intercourse.

Frotteurism

A person who develops frotteurism has repeated and intense sexual urges to touch and rub against a non consenting person or has sexually arousing fantasies of doing so. The person may also act on the urges. Frottage (from French *frotter,* "to rub") is usually committed in a crowd.

Pedophilia

A person with pedophilia gains sexual gratification by watching, touching, or engaging in sexual acts with prepubescent children, usually 13 years old or younger. Some people with this disorder are satisfied by child pornography or seemingly innocent material such as children's underwear ads; odd place, such as a subway or a busy sidewalk.

Sexual Sadism

A person with **sexual sadism**, usually male, is intensely sexually aroused by the thought or act of inflicting suffering on others by dominating, restraining, blindfolding, cutting, strangling, mutilating, or even killing the victim.

9.8 GENDER IDENTITY DISORDER

DSM-IV-TR categorizes these individuals as having **gender identity disorder**, a disorder in which people persistently feel that a vast mistake has been made, they have been born to the wrong sex, and gender changes would be desirable.

The DSM-IV-TR categorization of gender identity disorder is controversial. Many people believe that transgender experiences reflect alternative— not pathological—ways of experiencing one's gender identity. People with gender identity disorder would like to get rid of their primary and secondary sex characteristics—many of them find their own genitals repugnant—and acquire the characteristics of the other sex (APA, 2000).

Types of Gender Dysphoria Clients

Richard Carroll (2007), a leading theorist on gender dysphoria, has described the three patterns of gender identity disorder for which individuals most commonly seek treatment: (1) *female-to-male gender dysphoria,* (2) *male-to-female gender dysphoria: androphilic type,* and (3) *male-to-female gender dysphoria: autogynephilic type.*

Female-to-Male Gender Dysphoria

People with a female-to-male gender dysphoria pattern are born female but appear or behave in a stereotypically masculine manner from early on—often as young as 3 years of age or younger.

Male-to-Female Gender Dysphoria:

Androphilic Type People with an androphilic type of male-to-female gender dysphoria are born male but appear or behave in a stereotypically female manner from birth. As children, they are viewed as effeminate, pretty, and gentle; avoid rough games; and hate to dress in boys' clothing.

9.9 LET'S SUM IT UP

Anorexia nervosa is characterized by self-starvation and failure to maintain normal body weight, intense fears of becoming over weight, and distorted body image. Bulimia nervosa involves preoccupation with weight control and body shape, repeated binges, and regular purging to keep weight down. Binge-eating disorder (BED) involves a recurrent pattern of binge eating that is not accompanied by compensatory

behaviors such as purging. People with BED tend to be older than those with anorexia or bulimia and are more likely to be obese. Eating disorders typically begin in adolescence and affect more females than males. Anorexia nervosa and bulimia nervosa are linked to preoccupations with weight control and maladaptive ways of trying to keep weight down. Many other factors are implicated in their development, including social pressures on young women to adhere to unrealistic standards of thinness, issues of control, underlying psychological problems, and conflict within the family, especially over issues of autonomy.

Insomnia disorder is often associated with worry and anxiety, especially performance anxiety associated with overconcern about not getting enough sleep. Hypersomnolence disorder involves excessive daytime sleepiness, whereas narcolepsy involves the occurrence of abrupt sleep attacks during waking hours. Narcolepsy may involve genetic factors and loss of brain cells in the hypothalamus involved in producing a chemical that regulates wakefulness. Breathing-related sleep disorders involve recurrent episodes of momentary cessation of breathing during sleep and are often associated with daytime sleepiness. Obstructive sleep apnea hypopnea syndrome, the most common type of breathing-related sleep disorder, is typically caused by respiratory problems.

Personality disorders are maladaptive or rigid behavior patterns or personality traits associated with states of personal distress that impair the person's ability to function in social or occupational roles.
People with personality disorders do not generally recognize the need to change themselves. The three major clusters of personality disorders are categorized on the basis of the following characteristics: (1) odd or eccentric behavior, (2) dramatic, emotional, or erratic behavior, and (3) anxious or fearful behavior. Impulse-control disorders are psychological disorders characterized by a pattern of repeated failure to resist impulses to perform acts that lead to harmful consequences to self or others. People affected by these disorders experience a rising level of tension or arousal just before the act, then a sense of relief or release when the act is committed

A sexual dysfunction is a persistent or recurrent pattern involving lack of sexual desire, problems in becoming sexually aroused, and/or problems in reaching orgasm. Sexual dysfunctions can be classified in three general categories: (1) disorders involving low sexual desire or impaired arousal (female sexual interest/arousal disorder, male hypoactive sexual desire disorder, erectile disorder); (2) disorders involving impaired orgasmic response (female orgasmic disorder, delayed ejaculation, and premature or early ejaculation); and (3) disorders involving sexual pain (genito-pelvic pain/penetration disorder)..

9.10 Unit End Exercise

1. Describe causal factors involved in anorexia nervosa and bulimia nervosa. Identify factors linked to obesity
2. Evaluate problems associated with the classification of personality disorders.
3. Evaluate methods used to treat personality disorders.
4. Define the concept of impulse-control disorders and describe the features of several major types.

9.11 Answers for Check your Progress

1. The most obvious characteristic of anorexia nervosa is extreme emaciation, or more technically, the refusal to maintain a minimally normal body weight.
2. Almost all people with bulimia nervosa engage in purging, designed to eliminate consumed food from the body.
3. Somnabulism means sleep Walking.
4. Narcolepsy is a different form of the sleeping problem. In addition to daytime sleepiness, people with narcolepsy experience *cataplexy,* a sudden loss of muscle tone.
5. Dependent personality disorder describes people who have an excessive need to be taken care of by others. This leads them to be overly submissive and clinging in their relationships and extremely fearful of separation.
6. Kleptomania is characterized by repeated acts of compulsive stealing.

9.12 Suggested Readings

1. Carson, r.c., Butcher, J.N and Mineka, S.(2004). Abnormal psychology. 13th Edition.
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UNIT10

CLASSIFICATION OF MENTAL DISORDER AND ORGANIC MENTAL DISORDERS

Structure

10.1 Introduction

The use of a common language to describe observed clinical phenomena is critical to both clinical practice and research. These common terms for symptoms and categories allow the new clinician to develop a relatively accurate picture of the patient. Using diagnostic labels to describe sets of symptoms helps clinicians and researchers communicate about their patients. Deciding which diagnosis best fits a patient's pattern of symptoms also helps the clinician develop an appropriate treatment plan. The way clinicians refer to mental disorders has changed over the years as our understanding of these disorders continues to evolve.

10.2 Objectives

On completion of this unit, you will be able to understand

- Classifications - DSM & ICD
- Cognitive Disorders such as Dementia, Delirium, Amnestic disorder and their causes and treatment.

10.3 HISTORY OF CLASSIFICATION OF ABNORMAL BEHAVIORS

In 1952 the American Psychiatric Association (APA) adopted a classification system— the ***Diagnostic and Statistical Manual of Mental Disorders (DSM-I)*** (APA, 1952)—from an earlier system developed in 1918 to provide the Bureau of the Census with uniform statistics about psychiatric hospitals. The 1952 DSM manual contained 106 categories of mental disorders. From that point forward, the DSM has expanded. Published in 1968, the DSM-II (APA, 1968) listed 182 disorders in 134 pages and reflected the dominant psychodynamic perspective of the time. Symptoms were described as reflections of broad underlying conflicts or maladaptive reactions to life problems rather than in observable behavioral terms (Wilson, 1993). In 1974, the task force working to revise the DSM emphasized the importance of establishing more specific diagnostic criteria. The intention was to facilitate mental health research and to establish classifications that would reflect current scientific knowledge.

In the DSM-III (APA, 1980), categorization was based on description rather than assumptions about the causes of the disorder, and a more biomedical approach replaced the psychodynamic perspective (Wilson, 1993). The DSM-III, published in 1980, was more than three times the size of the earlier DSM and described twice as many diagnostic categories (265). The controversial expansion included many new diagnostic categories. For example, the former category of anxiety neurosis was divided into several different and distinct categories including generalized anxiety disorder, panic disorder, and social phobia. All subsequent revisions have maintained the structure of the DSM-III and have attempted to refine or improve this version rather than to overhaul the diagnostic system entirely. The next version, the DSM-III-R (APA, 1987) included not only revisions but also renaming, reorganization, and replacement of several disorders, which yielded 292 diagnoses.

In 1994, DSM-IV listed 297 disorders. This revision emerged from the work of a steering committee, consisting of work groups of experts who (a) conducted an extensive literature review of the diagnoses, (b) obtained data from researchers to determine which criteria to change, and (c) conducted multicenter clinical trials (Schaffer, 1996). DSM-IV-TR (APA, 2000), a "text" revision, was published in 2000 with most diagnostic criteria unaltered. This revision primarily provided updated information on each diagnosis and was more consistent with *International Classification of Diseases-10* published by the World Health Organization (discussed later in this chapter). As we continue to learn more about psychopathology, the DSM continues to evolve.

The next version, the DSM-V, released in May 2013. Although many valid criticisms have arisen as a reaction to the DSM system, at its most useful, it provides a framework and common language for clinicians and researchers. The DSM system helps clinicians examine presenting problems and associated features and to identify appropriate assessments and treatments. Moreover, accurate classification of mental disorders is a critical element of rigorous research.

An alternative to the DSM classification system is the ***International Classification of Diseases and Related Health Problems (ICD)***. Published by the World Health Organization (WHO; 1992), the ICD uses a code-based classification system for physical diseases and a broad array of psychological symptoms and syndromes. The ICD system for diagnosing mental disorders was developed in Europe at approximately the same time that the original DSM was being developed in the United States, shortly after World War II. The first set of mental disorders was included in the ICD in 1948. The APA and WHO have worked to coordinate the DSM and the relevant sections of ICD, although some differences remain. Like the DSM system, the ICD is regularly revised; it is currently in its tenth edition (ICD-10 in 1992). The ICD has become the international standard diagnostic classification system for epidemiology and many health management purposes. Beyond its use in classifying diseases and other health problems, the ICD is used for morbidity and mortality statistics for the WHO and for third party payers and insurance companies (WHO, 2007).

The diagnosis and classification of psychological disorders are important for creating a common language for clinicians and researchers to facilitate communication about patients and psychological symptoms and syndromes. Diagnoses also help clinicians to develop appropriate treatment plans. The DSM system of classification is most often used in this country. An alternative classification system, the *International Classification of Diseases* (ICD), is used in Europe. _ Developmental, demographic, and cultural variables affect the nature and experience of abnormal behavior. These variables must be considered when evaluating the utility of diagnostic classification systems.

Check your Progress

1. What is the expansion for DSM &ICD?
2. Name the current version of DSM

10.4 Dementia

Dementia is a gradual worsening loss of memory and related cognitive functions, including the use of language, as well as reasoning and decision making. It is a clinical syndrome that involves progressive

impairment of many cognitive abilities. Dementia is a chronic, deteriorating condition that reflects the gradual loss of neurons in the brain. In dementia, memory and other cognitive functions are the most obvious manifestations of the problem. They are its defining features. As dementia progresses, the person's attention span, concentration, judgment, planning, and decision making become severely disturbed.

10.4.1 Symptoms

Cognitive Symptoms

Dementia appears in people whose intellectual abilities have previously been unimpaired. The earliest signs of dementia are often quite vague. They include difficulty remembering recent events and the names of people and familiar objects. These are all problems that are associated with normal aging, but they differ from that process in order of magnitude. The distinguishing features of dementia include cognitive problems in a number of areas, ranging from impaired memory and learning to deficits in language and abstract thinking. By the final stages of dementia, intellectual and motor functions may disappear almost completely.

Memory and Learning

The diagnostic hallmark of dementia is memory loss. **Retrograde amnesia** refers to the loss of memory for events prior to the onset of an illness or the experience of a traumatic event.

Anterograde amnesia refers to the inability to learn or remember new material after a particular point in time.

Verbal Communication

Language functions can also be affected in dementia. **Aphasia** is a term that describes various types of loss or impairment in language that are caused by brain damage. Language disturbance in dementia is sometimes relatively subtle, but it can include many different kinds of problems. In addition to problems in understanding and forming meaningful sentences, the demented person may also have difficulty performing purposeful movements in response to verbal commands, a problem known as **apraxia.**

Perception

Some patients with dementia have problems identifying stimuli in their environments. The technical term for this phenomenon is **agnosia,** which means "perception without meaning." The person's sensory functions are unimpaired, but he or she is unable to recognize the source of stimulation. Agnosia can be associated with visual, auditory, or tactile sensations.

Abstract Thinking

Another manifestation of cognitive impairment in dementia is loss of the ability to think in abstract ways. The person may be bound to concrete interpretations of things that other people say.

Judgment and Social Behavior

Related to deficits in abstract reasoning is the failure of social judgment and problem-solving skills. The disruption of short-term memory, perceptual skills, and higher-level cognitive abilities obviously causes disruptions of judgment.

Motor Behaviors

Demented persons may become agitated, pacing restlessly or wandering away from familiar surroundings. In the later stages of the disorder, patients may develop problems in the control of the muscles by the central nervous system. Some specific types of dementia are associated with involuntary movements, or dyskinesia— tics, tremors, and jerky

10.4.2 Causes:

Neurotransmitters

In patients suffering from dementia, the process of chemical transmission of messages within the brain is probably disrupted, Parkinson's disease are directly related to dopamine deficiencies. Other types of dementia have also been linked to problems with specific neurotransmitters. Huntington's disease may be associated with deficiencies in gamma-aminobutyric acid (GABA).

Viral Infections

Some forms of primary dementia are known to be the products of "slow" viruses—infections that develop over a much more extended

period of time than do most viral infections. Creutzfeldt-Jakob disease is one example.

Immune System Dysfunction

The immune system is the body's first line of defense against infection. It employs antibodies to break down foreign materials, such as bacteria and viruses, that enter the body. The regulation of this system allows it to distinguish between foreign bodies that should be destroyed and normal body tissues that should be preserved.

The production of these antibodies may be dysfunctional in some forms of dementia, such as Alzheimer's disease. In other words, the destruction of brain tissue may be caused by a breakdown in the system that regulates the immune system. The presence of beta-amyloid at the core of amyloid plaques is one important clue to the possible involvement of immune system dysfunction.

Environmental Factors Epidemiological investigations have discovered several interesting patterns that suggest that some types of dementia, especially Alzheimer's disease, may be related to environmental factors. One example is head injury, which can cause a sudden increase of amyloid plaque

10.5 Specific Disorders Associated with Dementia

10.5.1 Dementia of the Alzheimer's Type The speed of onset serves as the main feature to distinguish **Alzheimer's disease** from the other types of dementia listed in DSM-IV-TR. In this disorder, the cognitive impairment appears gradually, and the person's cognitive deterioration is progressive. If the person meets these criteria, the diagnosis is then made on the basis of excluding other conditions, Brain imaging procedures offer exciting new tools for the measurement of brain lesions associated with dementia. Scientists have developed a technique to detect amyloid plaques using positron emission tomography (PET imaging) in the living brain. This procedure may eventually replace the need to wait for autopsy to verify a diagnosis of Alzheimer's disease.

10.5.2 Huntington's Disease

Unusual involuntary muscle movements known as *chorea* (from the Greek word meaning "dance") represent the most distinctive feature of **Huntington's disease.** These movements are relatively subtle at first, with the person appearing to be merely restless or fidgety. As the disorder progresses, sustained muscle contractions become difficult. Movements of the face, trunk, and limbs eventually become uncontrolled, leaving the person to writhe and grimace. A large proportion of Huntington's patients also exhibit a variety of personality changes and symptoms of mental disorders, primarily depression and anxiety. The movement disorder and the cognitive deficits are produced by progressive neuronal degeneration in the basal ganglia.

10.5.3 Parkinson's Disease

A disorder of the motor system, known as *Parkinson's disease,* is caused by a degeneration of a specific area of the brain stem known as the substantia nigra and loss of the neurotransmitter dopamine, which is produced by cells in this area. Typical symptoms include tremors, rigidity, postural abnormalities, and reduction in voluntary movements. Unlike people with Huntington's disease, most patients with Parkinson's disease do not become demented. Follow-up studies suggest that approximately 20 percent of elderly patients with Parkinson's disease will develop symptoms of dementia. Their risk is approximately double the risk of dementia found among people of similar age who do not have Parkinson's disease.

Check your Progress

1. What is dementia?
2. What is Huntington disease?

10.6 Delirium

Delirium is a confusion state that develops over a short period of time and is often associated with agitation and hyperactivity. The most

important symptoms of delirium are disorganized thinking and a reduced ability to maintain and shift attention.
Delirium and dementia are produced by very different processes.

10.6.1 Symptoms

The primary symptom of delirium is clouding of consciousness in association with a reduced ability to maintain and shift attention.
The disturbance in consciousness might also be described as a reduction in the clarity of a person's awareness of his or her surroundings. Memory deficits may occur in association with impaired consciousness and may be the direct result of attention problems. The person's thinking appears disorganized, and he or she may speak in a rambling, incoherent fashion. Fleeting perceptual disturbances, including visual hallucinations, are also common in delirious patients. The symptoms of delirium follow a rapid onset—from a few hours to several days—and typically fluctuate throughout the day. The person may alternate between extreme confusion and periods in which he or she is more rational and clearheaded. Symptoms are usually worse at night.

10.6.2 Causes

The underlying mechanisms responsible for the onset of delirium undoubtedly involve neuropathology and neurochemistry. The incidence of delirium increases among elderly people, presumably because the physiological effects of aging make elderly people more vulnerable to medication side effects and cognitive complications of medical illnesses. Delirium can be caused by many different kinds of medication, including the following:

- Psychiatric drugs (especially antidepressants, antipsychotics, and benzodiazepines)
- Drugs used to treat heart conditions
- Painkillers
- Stimulants (including caffeine)

Delirium also develops in conjunction with a number of metabolic diseases, including pulmonary and cardiovascular disorders (which can interfere with the supply of oxygen to the brain), as well as endocrine diseases (especially thyroid disease and diabetes mellitus). Various kinds of infections can lead to the onset of delirium. Perhaps the most common among elderly people is urinary tract infection, which can result from the use of an indwelling urinary catheter (sometimes necessary with incontinent nursing home patients).

10.7 Amnestic Disorder

Some cognitive disorders involve more circumscribed forms of memory impairment than those seen in dementia. In amnestic disorders, a person exhibits a severe impairment of memory while other higher level cognitive abilities are un-affected. The memory disturbance interferes with social and occupational functioning and represents a significant decline from a previous level of adjustment. Subtypes of amnestic disorder are diagnosed on the basis of evidence, acquired from the patient's history, from a physical examination, or from laboratory tests, regarding medical conditions or substance use that is considered to be related to the onset of the memory impairment.

One widely accepted theory regarding this condition holds that lack of vitamin B1 (thiamine) leads to atrophy of the medial thalamus, a sub cortical structure of the brain, and mammillary bodies (MB). Support for one aspect of this theory comes from studies that used magnetic resonance imaging to compare brain structures in alcoholic patients with amnesia, alcoholic patients without amnesia, and normal controls. Deficits in MB volume occur in both types of alcoholics, and greater volume deficits are found in alcoholic patients with amnesia. Other data suggest, however, that these problems cannot be traced exclusively to thiamine deficiency.

Check your progress

3. What is delirium?
4. What is Amnestic Disorder?
5. Which is the primary symptoms of delirium?

10.8 Treatment and Management

10.8.1 Medication

Some drugs are designed to relieve cognitive symptoms of dementia by boosting the action of acetylcholine (ACh), a neurotransmitter that is involved in memory and whose level is reduced in patients with Alzheimer's disease. Unfortunately it usually works for only six to nine months and is not able to reverse the relentless progression of the disease.

10.8.2 Environmental and Behavioral Management

Patients with dementia experience fewer emotional problems and are less likely to become agitated if they follow a structured and predictable daily schedule. Activities such as eating meals, exercising, and going to bed are easier and less anxiety-provoking if they occur at regular times. The use of signs and notes may be helpful reminders for patients who are in the earlier stages of the disorder. As the patient's cognitive impairment becomes more severe, even simple activities, such as getting dressed or eating a meal, must be broken down into smaller and more manageable steps. Directions have to be adjusted so that they are appropriate to the patient's level of functioning. Patients with apraxia, for example, may not be able to perform tasks in response to verbal instructions. Caregivers need to adjust their expectations and assume increased responsibilities as their patients' intellectual abilities deteriorate.

10.8.3 Support for Caregivers

A final area of concern is the provision of support to people who serve as caregivers for demented patients. In India, spouses and other family members provide primary care for more than 80 percent of people who have dementia of the Alzheimer's type (Ballard, 2007). Their burdens are often overwhelming, both physically and emotionally.

10.9 Let's sum up

Dementia, delirium, and amnestic disorders are listed as Cognitive Disorders in DSM-IV-TR. Disruptions of memory and other cognitive functions are the most obvious symptoms of these disorders. Dementia is defined as a gradually worsening loss of memory and related cognitive functions, including the use of language as well as reasoning and decision making. Aphasia and apraxia are among the most obvious problems in verbal communication. Perceptual difficulties, such as **agnosia,** are also common. In amnestic disorder, the memory impairment is more circumscribed. The person may experience severe **anterograde amnesia,** but other higher-level cognitive abilities remain unimpaired. **Delirium** is a confusion state that develops over a short period of time and is often associated with agitation and hyperactivity. The causes of dementia include many different factors.

Some types of dementia are produced by viral infections and dysfunction of the immune system. Environmental toxins also may contribute to the onset of cognitive impairment. Behavioral and environmental management are important aspects of any treatment program for demented patients. They allow patients to reside in the least restrictive and safest possible settings. Respite programs provide much-needed support to caregivers, usually spouses and other family

10.10 Unit End Exercise

1. In what ways is delirium different from dementia?
2. Is memory impairment the only indication that a person is developing dementia?
3. Why is depression in an elderly person sometimes confused with dementia?
4. What are the most difficult problems faced by people caring for a person with dementia?

10.11 Answers for check Your Progress

1. Dementia is a gradual worsening loss of memory and related cognitive functions, including the use of language, as well as reasoning and decision making.
2. Unusual involuntary muscle movements known as Huntington's disease.
3. Delirium is a confusion state that develops over a short period of time and is often associated with agitation and hyperactivity.
4. In amnestic disorders, a person exhibits a severe impairment of memory while other higher level cognitive abilities are un-affected.
5. The primary symptom of delirium is clouding of consciousness in association with a reduced ability to maintain and shift attention.

10.12 Suggested Readings

1. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.
2. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.
3. Sarason and Sarason. (2010). Abnormal Psychology: The Problem of Maladaptive Behaviour (11th Edition). New Delhi. Prentice Hall of India Pvt. Ltd.

UNIT 11

STRESS RELATED AND SOMATOFORM DISORDERS

Structure

11.1 INTRODUCTION

Scientists define *stress* as any challenging event that requires physiological, cognitive, or behavioral adaptation. Stress may involve minor, daily hassles, like taking an exam, or major events, such as going through a divorce. The most common daily stressors involve interpersonal arguments and tensions. Scientists once thought that stress contributed to only a few physical diseases. Ulcers, migraine headaches, hypertension (high blood pressure), asthma, and a few other illnesses were thought to be *psychosomatic disorders.* The holistic view of health and disease has brought about major changes in medicine. Psychologists who specialize in behavioral medicine often are called *health psychologists.*

11.2 Objectives

By the end of this unit you will be able to understand

- Concept of stress
- Stress related disorders
- Causes of stress related disorder and
- Treatment

11.3 Defining Stress

We define **stress** as a challenging event that requires physiological, cognitive, or behavioral adaptation.

11.4 Psycho physiological Responses to Stress

Physiologically, the fight-or-flight response activates the *sympathetic nervous system:* Your heart and respiration rates increase, your blood pressure rises, your pupils dilate, your blood sugar levels elevate, and your blood flow is redirected in preparation for muscular activity. These physiological reactions heighten attention, provide energy for quick action, and prepare the body for injury.

11.5 Panic Disorder

Panic disorder is characterized by repeated, unexpected *panic attacks.* Panic attacks are intense anxiety reactions that are accompanied by physical symptoms such as a pounding heart; rapid respiration, shortness of breath, or difficulty breathing; heavy perspiration; and weakness or dizziness. There is a stronger bodily component to panic attacks than to other forms of anxiety. The attacks are accompanied by feelings of sheer terror and a sense of imminent danger or impending doom and by an urge to escape the situation.

11.5.1 Biological Factors

Evidence indicates that genetic factors contribute to proneness or vulnerability to panic disorder. Genes may create a predisposition or likelihood, but not a certainty that panic disorder or other psychological disorders will develop. The biological underpinnings of panic attacks may involve an unusually sensitive internal alarm system involving parts of the brain, especially the limbic system and frontal lobes that normally become involved in responding to cues of threat or danger. Let's also consider the role of neurotransmitters, especially *gamma-aminobutyric acid* (GABA). GABA is an *inhibitory* neurotransmitter, which means that it tones down excess activity in the central nervous system and helps quell the body's response to stress.

11.5.2 Cognitive Factors

The role of cognitive factors may play in determining oversensitivity of panic-prone people to biological challenges, such as manipulation of carbon dioxide levels in the blood. These challenges produce intense physical sensations that panic-prone people may misinterpret as signs of an impending heart attack or loss of control. Perhaps these misinterpretations—not any underlying biological sensitivities per se—are responsible for inducing the spiraling of anxiety that can quickly lead to a panic attack. The fact that panic attacks often

seem to come out of the blue seems to support the belief that the attacks are biologically triggered

11.5.3 Treatment Approaches

The most widely used forms of treatment for panic disorder are drug therapy and cognitive behavioral therapy. Drugs commonly used to treat depression, called *antidepressant drugs,* also have anti-anxiety and anti-panic effects. Cognitive-behavioral therapists use a variety of techniques in treating panic disorder, including coping skills development for handling panic attacks, breathing retraining and relaxation training to reduce states of heightened bodily arousal, and exposure to situations linked to panic attacks and bodily cues associated with panicky symptoms. The therapist may help clients think differently about changes in bodily cues, such as sensations of dizziness or heart palpitations.

11.6 Phobic Disorders

The word phobia derives from the Greek *phobos*, meaning "fear." The concepts of fear and anxiety are closely related. *Fear* is anxiety experienced in response to a particular threat. A phobia is a fear of an object or situation that is disproportionate to the threat it poses. A curious thing about phobias is that they usually involve fears of the ordinary events in life, such as taking an elevator or driving on a highway, not the extraordinary. Phobias can become disabling when they interfere with daily tasks such as taking buses, planes, or trains; driving; shopping; or even leaving the house.
Specific Phobias A specific phobia is a persistent, excessive fear of a specific object or situation that is out of proportion to the actual danger these objects or situations pose.

There are many types of specific phobias, including the following (APA, 2013):

- Fear of animals, such as fear of spiders, insects, and dogs

• Fear of natural environments, such as fear of heights (*acrophobia*), storms, or water
• Fear of blood-injection injury, such as fear of needles or invasive medical procedures
• Fear of specific situations, such as fear of enclosed spaces (*claustrophobia*), elevators,

The phobic person experiences high levels of fear and physiological arousal when encountering the phobic object, which prompts strong urges to avoid or escape the situation or to avoid the feared stimulus,

Psychodynamic Perspectives

A phobic reaction is a projection of the person's own threatening impulses onto the phobic object. For instance, a fear of knives or other sharp instruments may represent the projection of one's own destructive impulses onto the phobic object. The phobia serves a useful function.

11.6.1 Biological Perspectives

Genetic factors can predispose individuals to develop anxiety disorders such as panic disorder and phobic disorder.
For one thing, we've learned that people with variations of particular genes are more prone to develop fear responses and to have greater difficulty overcoming them. For example, people with a variation of a particular gene who are exposed to fearful stimuli show greater activation of a brain structure called the *amygdala,* an almond-shaped structure in the brain's limbic system. The amygdala produces fear responses to triggering stimuli without conscious thought. It works as a kind of "emotional computer" whenever we encounter a threat or danger.

11.6.2 Cognitive Perspectives

Research highlights the importance of cognitive factors in determining proneness to phobias, including factors such as oversensitivity to threatening cues, over predictions of dangerousness, and self-defeating thoughts and irrational beliefs

1. *Oversensitivity to threatening cues.* People with phobias tend to perceive danger in situations most people consider safe, such as riding on elevators or d riving over bridges. Similarly, people with social anxiety tend to be overly sensitive to social cues of rejection or negative evaluation from others (Schmidt et al., 2009).
2. *Over prediction of danger.* Phobic individuals tend to over predict how much fear or anxiety they will experience in the fearful situation. The person with a snake phobia, for example, may expect to tremble when he or she encounters a snake in a cage.
3. *Self-defeating thoughts and irrational beliefs.* Self-defeating thoughts can heighten and perpetuate anxiety and phobic disorders. When faced with fear-evoking stimuli, the person may think, "I've got to get out of here," or "My heart is going to leap out of my chest."

11.6.3 Treatment Approaches

The major contemporary treatment approaches to specific phobias, as for other anxiety disorders, derive from the learning, cognitive, and biological perspectives.

Learning-Based Approaches

A substantial body of research demonstrates the effectiveness of learning-based approaches in treating a range of anxiety disorders. At the core of these approaches is the effort to help individuals cope more effectively with anxiety-provoking objects and situations. Examples of learning-based approaches include *systematic desensitization, gradual exposure,* and *flooding*

Systematic desensitization is based on the assumption that phobias are learned or conditioned responses that can be unlearned by substituting an incompatible response to anxiety in situations that usually elicit anxiety. Muscle relaxation is generally used as the incompatible response. Systematic desensitization creates a set of conditions that can lead to extinction of fear responses. The technique fosters extinction by providing opportunities for repeated exposure to phobic stimuli in imagination without aversive consequences.

Gradual exposure uses a stepwise approach in which phobic individuals gradually confront the objects or situations they fear.

Repeated exposure to a phobic stimulus in the absence of any aversive event ("nothing bad happening") can lead to extinction, or gradual weakening, of the phobic response, even to the point that it is eliminated

Flooding is a form of exposure therapy in which subjects are exposed to high levels of fear-inducing stimuli either in imagination or in real-life situations. *Why?* The belief is that anxiety represents a conditioned response to a phobic stimulus and should dissipate if the individual remains in the phobic situation for a long enough period of time without harmful consequences.

Cognitive Therapy

Cognitive therapists seek to identify and correct dysfunctional or distorted beliefs. For example, people with social anxiety might think no one at a party will want to talk with them and that they will wind up lonely and isolated for the rest of their lives. One example of a cognitive technique is cognitive restructuring, a method in which therapists help clients pinpoint self-defeating thoughts and generate rational alternatives they can use to cope with anxiety-provoking situations.

Drug Therapy

Evidence also supports the use of antidepressant drugs, in treating social anxiety. A combination of psychotherapy and drug therapy in the form of antidepressant medication may be more effective in some cases than either treatment approach alone.

Check your progress

1. What is phobia and acrophobia?
2. What is flooding?

11.7 Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is characterized by excessive anxiety and worry that is not limited to any one object, situation, or activity. Normally, anxiety can be an adaptive response, a kind of built-in bodily warning system to signal when something is threatening and requires immediate attention. But for people with generalized anxiety

disorder, anxiety becomes excessive, becomes difficult to control, and is accompanied by physical symptoms.

From a learning perspective, generalized anxiety is precisely that: generalization of anxiety across many situations. People concerned about broad life themes, such as finances, health, and family matters, are likely to experience apprehension or worry in a variety of settings. Anxiety would thus become connected with almost any environment or situation.

11.7.1 The cognitive perspective

GAD emphasizes the role of exaggerated or distorted thoughts and beliefs, especially beliefs that underlie worry. People with GAD tend to worry just about everything. They also tend to be overly attentive to threatening cues in the environment, perceiving danger and calamitous consequences at every turn. Consequently, they feel continually on edge, as their nervous systems respond to the perception of threat or danger with activation of the sympathetic nervous system, leading to increased states of bodily arousal and the accompanying feelings of anxiety, and symptoms such as restlessness, jumpiness, and muscle tension. The central feature of GAD is excessive worry. People with GAD tend to be chronic worriers—even lifelong worriers. They may worry about many things, including their health, their finances, the well-being of their children, and their social relationships. The emotional distress associated with GAD interferes significantly with the person’s daily life. GAD frequently occurs together with other disorders, including depression or other anxiety disorders such as agoraphobia and obsessive–compulsive disorder.

The cognitive and biological perspectives converge in evidence showing irregularities in the functioning of the amygdala in GAD patients and in its connections to the brain’s thinking center, the prefrontal.

11.7.2 Treatment Approaches

The major forms of treatment of generalized anxiety disorder are psychiatric drugs and cognitive- behavioral therapy. Antidepressant drugs can help relieve anxiety symptoms. Bear in mind, however, that although psychiatric drugs may help relieve anxiety, they do not cure the

underlying problem. Once the drugs are discontinued, the symptoms often return. Cognitive-behavioral therapists use a combination of techniques in treating GAD, including training in relaxation skills; learning to substitute calming, adaptive thoughts for intrusive, worrisome thoughts; and learning skills of de-catastrophizing

11.8 Obsessive–Compulsive Disorder

People with obsessive–compulsive disorder (OCD) are troubled by recurrent obsessions or compulsions, or both obsessions and compulsions, that are time-consuming, such as lasting more than an hour a day, or causing significant distress or interference with a person's normal routines or occupational or social functioning.

An obsession is a recurrent, persistent, and unwanted thought, urge, or mental image that seems beyond the person's ability to control. Obsessions can be potent and persistent enough to interfere with daily life and can engender significant distress and anxiety.

A compulsion is a repetitive behavior (e.g., hand washing or checking door locks) or mental act (e.g., praying, repeating certain words, or counting) that the person feels compelled or driven to perform (APA, 2013). Compulsions typically occur in response to obsession thoughts and are frequent and forceful enough to interfere with daily life or cause significant distress. Compulsions often accompany obsessions and may at least partially relieve the anxiety created by obsession thinking.

11.8.1 Theoretical Perspectives

Within the psychodynamic tradition, obsessions represent leakage of unconscious urges or impulses into consciousness, and compulsions are acts that help keep these impulses repressed. Obsessive thoughts about contamination by dirt or germs may represent the threatened emergence of unconscious infantile wishes to soil one self and play with feces.

Vulnerability to OCD is in part determined by genetic factor. Just what genes are involved in OCD remains under study, but research evidence points to a possible role for a gene that works to tone down the

actions of a particular neurotransmitter, *glutamate,* at least in some cases of the disorder Another possibility is that the actions of particular genes affect chemical balances in the brain that lead to over arousal of a network of neurons called a *worry circuit,* a neural network that signals danger in response to perceived threats. In OCD, the brain may be continually sending messages through this "worry circuit" or neural circuit that something is wrong and requires immediate attention, leading to obsession, worrisome thoughts and repetitive, compulsive behaviors.

Other parts of the brain, including the basal ganglia, may also be involved in OCD. The basal ganglia are involved in controlling body movements, so it is conceivable that a dysfunction in this region might help explain the ritualistic behaviors seen in OCD patients.

Psychological models

OCD emphasize cognitive and learning-based factors. They can't seem to break the mental loop in which the same intrusive, negative thoughts keep reverberating in their minds. They also tend to exaggerate the risk that unfortunate events will occur. Because they expect terrible things to happen, people with OCD engage rituals.

Another cognitive factor linked to the development of OCD is perfectionism, or belief that one must perform flawlessly. People who hold perfectionist beliefs exaggerate the consequences of turning in less-than perfect work and may feel compelled to redo their efforts until every detail is flawless.

11.8.2 Treatment Approaches

Behavior therapists have achieved impressive results in treating obsessive–compulsive disorder with the technique of *exposure with response prevention* (ERP). The *exposure* component involves exposure to situations that evoke obsessive thoughts. For many people, such situations are hard to avoid. Through exposure with response prevention, people with OCD learn to tolerate the anxiety triggered by their obsessive thoughts while they are prevented from performing their compulsive rituals. With repeated exposure trials, the anxiety eventually

subsides, and the person feels less compelled to perform the accompanying rituals SSRI anti-depressants also have therapeutic benefits in treating OCD.

Check your Progress

3. What is obsession?
4. What is compulsion?
5. What is ERP?

11.9 Body Dysmorphic Disorder

People with body dysmorphic disorder (BDD) are preoccupied with an imagined or exaggerated physical defect in their appearance, such as skin blemishes, wrinkling or swelling of the face, body moles or spots, or facial swelling, causing them to feel they are ugly or even disfigured. They fear others will judge them negatively on the basis of their perceived defect or flaw. They may spend hours examining themselves in the mirror and go to extreme measures to correct the perceived defect, even undergoing invasive or unpleasant medical procedures, including unnecessary plastic surgery.

BDD is classified within the obsessive–compulsive spectrum because people with the disorder often become obsessed with their perceived defect and often feel compelled to check themselves in the mirror or engage in compulsive behaviors aimed at fixing, covering, or modifying the perceived defect.

Exposure therapy with response prevention is often used in treating body dysmorphic disorder. Exposure can take the form of intentionally revealing the perceived defect in public, rather than concealing it with makeup or clothing. Response prevention may involve efforts to avoid mirror checking (e.g., by covering mirrors at home) and excessive grooming. ERP is generally combined with cognitive restructuring, in which therapists help clients challenge their distorted beliefs about their physical appearance and evaluate them in light of evidence.

11.9.1 Somatic Disorders

The word *somatic* derives from the Greek *soma,* meaning "body." People with somatic disorders (formerly called *somatoform disorders*) may have physical ("somatic") symptoms without an identifiable physical cause or have excessive concerns about the nature or meaning of their symptoms. The symptoms significantly interfere with the people's lives and often lead them to go "doctor shopping" in the hope of finding a medical practitioner who can explain and treat their ailments. The concept of somatic symptom and related disorders presumes that psychological processes affect physical functioning. For example, some people complain of problems in breathing or swallowing, or a "lump in the throat." Such problems can reflect over activity of the sympathetic branch of the autonomic nervous system, which might result from anxiety.

1.9.3 Somatic Symptom Disorder

Most people have physical symptoms somewhere along life's course. It is normal to feel concerned about one's physical symptoms and to seek medical attention. However, people with somatic symptom disorder (SSD) not only have troubling physical symptoms, but they are excessively concerned about their symptoms to the extent that it affects their thoughts, feelings, and behaviors in daily life. Thus, the diagnosis emphasizes the psychological features of physical symptoms, not whether the underlying cause or causes of the symptoms can be medically explained.

11.9.3Hypochondrias, which applied to people with physical complaints who believed they are suffer with a serious, undetected illness, such as cancer or heart disease, despite medical reassurance to the contrary. For example, a person suffering from headaches may fear that they are a sign of a brain tumor and believe doctors are wrong when they say these fears are groundless. At the core of hypochondrias is health anxiety, a preoccupation that one's physical symptoms are signs of something terribly wrong with one's health.

Hypochondrias is believed to affect about 1% to 5% of the general population and about 5% of patients seeking medical care. People with hypochondrias do not consciously fake their symptoms. They feel real physical discomfort, often involving their digestive system or an assortment of aches and pains throughout the body. They may be overly sensitive to benign changes in physical sensations, such as slight changes in heartbeat and minor aches and pains.

Anxiety about physical symptoms can produce its own physical sensations, however— for example, heavy sweating and dizziness, even fainting. Thus, a vicious cycle may ensue. Patients may become resentful when their doctors tell them that their own fears may be causing their physical symptoms.

11.9.4 Conversion Disorder

Conversion disorder (called *functional neurological symptom disorder* in *DSM-5*) is characterized by symptoms or deficits that affect the ability to control voluntary movements (inability to walk or move an arm, for example) or that impair sensory functions, such as an inability to see, hear, or feel tactile stimulation (touch, pressure, warmth, or pain). In some cases, however, what appears to be conversion disorder actually turns out to be intentional fabrication or faking of symptoms for some external gain (malingering). Unfortunately, clinicians lack the ability to reliably determine that someone is faking.

The physical symptoms in conversion disorder usually come on suddenly in stressful situations. A soldier's hand may become "paralyzed" during intense combat, for example. The fact that conversion symptoms first appear in the context of, or are aggravated by, conflicts or stressors suggests a psychological connection. Some classic symptom patterns take the form of paralysis, epilepsy, problems in coordination, blindness and tunnel vision, loss of the sense of hearing or of smell, or loss of feeling in a limb (anesthesia). The bodily symptoms found in conversion disorders often do not match the medical conditions.

Psychodynamic Theory

According to psychodynamic theory, hysterical symptoms are functional: They allow the person to achieve *primary gains* and *secondary gains.* The primary gain of the symptoms is to allow the individual to keep internal conflicts repressed. The person is aware of the physical symptom but not of the conflict it represents. Secondary gains from the symptoms are those that allow the individual to avoid burdensome responsibilities and to gain the support—rather than condemnation—of those around them. For example, soldiers sometimes experience sudden "paralysis" of their hands, which prevents them from firing their guns in battle. From the learning perspective, people with somatic symptom and related disorders may also carry the benefits, or reinforcing properties, of the "sick role." People with conversion disorders, for instance, may be relieved of chores and responsibilities such as going to work or performing household tasks. Being sick also usually earns sympathy and support.

Cognitive Theory

From a cognitive perspective, we can think about hypochondrias in some cases as a type of self-handicapping strategy, a way of blaming poor performance on failing health. In other cases, diverting attention to physical complaints may serve as a means of avoiding thinking about other life problems. Another cognitive explanation focuses on the role of distorted thinking. People with hypochondrias have a tendency to exaggerate the significance of minor physical complaints

Treatment of Somatic Disorders

Psychoanalysis seeks to uncover and bring into conscious awareness unconscious conflicts that originated in childhood. Once the conflict is aired and worked through, the symptom is no longer needed and should disappear.

The behavioral approach to treatment focuses on removing sources of secondary reinforcement (or secondary gain) that may become connected with physical complaints. Family members and others, for example, often perceive individuals with these disorders as sickly and

incapable of carrying out normal responsibilities. This reinforces dependent and complaining behaviors. The behavior therapist may teach family members to reward attempts to assume responsibility and to ignore nagging and complaining.

The cognitive technique of restructuring distorted thinking helps clients identify and replace exaggerated illness-related beliefs with rational alternatives. The behavioral technique of *exposure with response prevention,* can help patients with somatic symptom disorder and illness anxiety disorder break the pattern of running to doctors for reassurance whenever they experience some worrisome, health-related concerns. These individuals can also benefit from breaking problem habits, such as repeatedly checking the Internet for illness-related information and reading newspaper obituaries.

11.10 Let's sum up

Stress takes its toll on our physical and psychological well-being. In the *DSM-IV-TR*, Axis IV is used to note any psychosocial stressors that may contribute to or result from an Axis I disorder. When we are stressed, the autonomic nervous system responds in a variety of ways. One consequence of stress is increased production of cortisol. High levels of this stress hormone may be beneficial in the short term but problematic over the longer term.

The *DSM-IV-TR* classifies people's psychological problems in response to stressful situations under two general categories: adjustment disorders and posttraumatic stress disorder (which is a form of anxiety disorder). Several relatively common stressors (prolonged unemployment, loss of a loved one through death, and marital separation or divorce) may produce a great deal of stress and psychological maladjustment, resulting in adjustment disorder. More intense psychological disorders in response to trauma or excessively stressful situations (such as military combat, being held hostage, or torture) may be categorized as posttraumatic stress disorder.

PTSD can involve a variety of symptoms including intrusive thoughts and repetitive nightmares about the event, intense anxiety, avoidance of stimuli associated with the trauma, and increased arousal manifested as

chronic tension, irritability, insomnia, impaired concentration and memory, and depression. Although it is very common to experience psychological symptoms after a traumatic event, these often fade with time. Most people exposed to traumatic events do not develop PTSD. The prevalence of PTSD in the general population is 6.8 percent. If symptoms begin 6 months or more after the traumatic event, the diagnosis is delayed posttraumatic stress disorder. Medications are sometimes used in the treatment of PTSD. Psychological treatments include prolonged exposure therapy and cognitive therapy. A new approach that appears promising is the use of virtual reality exposure therapy.

11.11 Unit end Exercise

1. Describe the biological changes that occur when we are under stress.
2. What is cortisol? Is cortisol beneficial or harmful? What is the main difference between acute stress disorder and PTSD?
3. What risk factors are associated with experiencing trauma?
4. What risk factors are implicated in the development of PTSD?

11.12 Answers for check your Progress

1. A phobia is a fear of an object or situation that is disproportionate to the threat it poses, fear of heights.
2. **Flooding** is a form of exposure therapy in which subjects are exposed to high levels of fear-inducing stimuli either in imagination or in real-life situations.
3. An obsession is a recurrent, persistent, and unwanted thought, urge, or mental image that seems beyond the person's ability to control.
4. A compulsion is a repetitive behavior (e.g., hand washing or checking door locks) or mental act (e.g., praying, repeating certain words, or counting) that the person feels compelled or driven to perform.
5. The *exposure* component involves exposure to situations that evoke obsessive thoughts. For many people, such situations are hard to avoid. Through exposure with response prevention, people with OCD learn to tolerate the anxiety triggered by their obsessive thoughts while they are prevented from performing their compulsive rituals.

11.13 Suggested Readings

1. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.
2. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.
3. Sarason and Sarason. (2010). Abnormal Psychology: The Problem of Maladaptive Behaviour (11th Edition). New Delhi. Prentice Hall of India Pvt. Ltd.

Unit 12

ADDITIVE DISORDERS

Structure

12.1 INTRODUCTION

The costs of substance abuse are astronomical. According to the World Health Organization, alcohol use was responsible for 5 percent of the total burden of disease and disability worldwide in 2004. Cirrhosis of the liver, which is frequently the result of chronic alcoholism, is a leading cause of death in India. In addition, alcohol plays a prominent role in many suicides, homicides, and motor vehicle accidents.

12.2 Objectives

On completion of this unit you will be able to understand

- Types of substance related disorder
- Different groups of drugs
- Causes of substance abuse
- Treatment

12.3 Substance used disorder

DSM-IV-TR uses two terms to describe substance use disorders, and these terms reflect different levels of severity. **Substance dependence,** the more severe of the two forms, refers to a pattern of repeated self-administration that often results in tolerance, the need for increased amounts of the drug to achieve intoxication; withdrawal, unpleasant physical and psychological effects that the person experiences when he or she tries to stop taking the drug; and compulsive drug-taking behavior. **Substance abuse** describes a more broadly conceived, less severe pattern of drug use that is defined in terms of interference with the person's ability to fulfill major role obligations at work or at home, the recurrent use of a drug in dangerous situations, and repeated legal difficulties associated with drug use.

Addiction is another term that is often used to describe problems such as alcoholism. It is essentially synonymous with substance dependence, although it does not appear in DSM-IV-TR. A **drug of abuse,** sometimes called a *psychoactive substance*, is a chemical substance that alters a person's mood, level of perception, or brain functioning.

Despite these differences, the various forms of substance abuse share many common elements. All forms of abuse represent an inherent conflict between immediate pleasure and longer-term harmful consequences. The psychological and biochemical effects on the user are often similar, as are the negative consequences for both social and occupational.

12.4 Alcohol

Alcohol affects virtually every organ and system in the body. After alcohol has been ingested, it is absorbed through membranes in the stomach, small intestine, and colon. The rate at which it is absorbed is influenced by many variables, including the concentration of alcohol in the beverage (for example, distilled spirits are absorbed more rapidly than beer or wine), the volume and rate of consumption, and the presence of food in the digestive system. After it is absorbed, alcohol is distributed to all the body's organ systems. Almost all the alcohol that a person consumes is eventually broken down or metabolized in the liver.

Short-Term Effects

Blood alcohol levels are measured in terms of the amount of alcohol per unit of blood. According to DSM-IV-TR, the symptoms of alcohol intoxication include slurred speech, lack of coordination, an unsteady gait, nystagmus (involuntary to-and-fro movement of the eyeballs induced when the person looks upward or to the side), impaired attention or memory, and stupor or coma.

Long-Term Consequences

The prolonged use and abuse of alcohol can have a devastating impact on many diseases. Many people who abuse alcohol experience blackouts. In some cases, abusers may continue to function without passing out, but they will be unable to remember their behavior. The disruption of relationships with family and friends can be especially painful. On a biological level, prolonged exposure to high levels of alcohol can disrupt the functions of several important organ systems, especially the liver, pancreas, gastrointestinal system, cardiovascular system, and endocrine system. The symptoms of alcoholism include

many secondary health problems, such as cirrhosis of the liver, heart problems (in part, the result of being overweight), and various forms of cancer, as well as severe and persistent forms of dementia and memory impairment or amnestic disorders.

12.5 Nicotine

Nicotine is the active ingredient in tobacco, which is its only natural source. Nicotine is almost never taken in its pure form because it can be toxic. Very high doses have extremely unpleasant effects. Controlled doses are easier to achieve by smoking or chewing tobacco, which provides a diluted concentration of nicotine. Another way of ingesting nicotine is to inhale snuff (powdered tobacco) into the nostrils. When tobacco smoke is inhaled, nicotine is absorbed into the blood through the mucous membranes of the lungs.

Short-Term Effects

The effects of nicotine on the peripheral nervous system include increases in heart rate and blood pressure. In the central nervous system, nicotine has pervasive effects on a number of neurotransmitter systems. It stimulates the release of norepinephrine from several sites, producing CNS arousal. Nicotine also causes the release of dopamine and norepinephrine in the mesolimbic dopamine pathway, Nicotine has a complex influence on subjective mood states. Many people say that they smoke because it makes them feel more relaxed.

Long-Term Consequences

Nicotine is one of the most harmful and deadly addicting drugs. Considerable evidence points to the development of both tolerance and withdrawal symptoms among people who regularly smoke or chew tobacco. Physiological symptoms of withdrawal from nicotine include drowsiness, lightheadedness, headache, muscle tremors, and nausea. People who smoke tobacco increase their risk of developing many fatal diseases, including heart disease, lung disease (bronchitis and emphysema), and various types of cancer. Eighty percent of all deaths caused by lung cancer can be attributed to smoking tobacco.

12.6 Amphetamine and Cocaine

Members of the class of drugs known as **psychomotor stimulants** produce their effects by simulating the actions of certain neurotransmitters, specifically epinephrine, norepinephrine, dopamine, and serotonin. Cocaine is a naturally occurring stimulant drug that is extracted from the leaf of a small tree that grows at high elevations, as in the Andes Mountains. The amphetamines (such as Dexedrine and methamphetamine) are produced synthetically. The stimulants can be taken orally, injected, or inhaled. It is easier to maintain a constant blood level when the drugs are taken orally. They are absorbed more slowly through the digestive system, and their effects are less potent. More dramatic effects are achieved by injecting the drug or sniffing it.

Short-Term Effects

Cocaine and amphetamines are called stimulants because they activate the sympathetic nervous system. They increase heart rate and blood pressure and dilate the blood vessels and the air passages of the lungs. Stimulants also suppress the appetite and prevent sleep. These effects have been among the reasons for the popularity and frequent abuse of stimulants. Acute overdoses of stimulant drugs can result in irregular heartbeat,

Long-Term Consequences

High doses of amphetamines and cocaine can lead to the onset of psychosis. The risk of a psychotic reaction seems to increase with repeated exposure to the drug. The symptoms of amphetamine psychosis include auditory and visual hallucinations, as well as delusions of persecution and grandeur. As with other forms of addiction, the most devastating effects of stimulant drugs frequently center the disruption of occupational and social roles.

12.7 Opiates

The **opiates** (sometimes called opioids) are drugs that have properties similar to those of opium. The natural source of opium is a poppy with a white flower. The main active ingredients in opium are morphine and codeine, both of which are widely used in medicine, particularly to relieve pain. The opiates can be taken orally, injected, or inhaled. Opium is sometimes eaten or smoked.

Short-Term Effects

The opiates can induce a state of dreamlike euphoria, which may be accompanied by increased sensitivity in hearing and vision. People who inject morphine or heroin also experience a rush—a brief, intense feeling of pleasure that is sometimes described as being an orgasm in the entire body. The opiates can induce nausea and vomiting among novice users, constrict the pupils of the eye, and disrupt the coordination of the digestive system. Continued use of opiates decreases the level of sex hormones in women and men, resulting in reduced sex drive and impaired fertility.

Long-Term Consequences

The effects of opiates on occupational performance and health depend in large part on the amount of drugs that the person takes. People who are addicted to opiates become preoccupied with finding and using the drug, in order to experience the rush and to avoid withdrawal symptoms. Tolerance develops rather quickly, and the person's daily dose increases regularly until it eventually levels off and remains steady.

12.8 Cannabis

Marijuana and hashish are derived from the hemp plant, *Cannabis sativa*. The most common active ingredient in cannabis is a compound called delta-9-tetrahydro-cannabinol (THC). Because every part of the plant contains THC, cannabis can be prepared for consumption in several ways. **Marijuana** refers to the dried leaves and flowers, which can be smoked in a cigarette or pipe. It can also be baked in brownies and ingested orally. **Hashish** refers to the dried resin from the top of the female cannabis plant. It can be smoked or eaten after being baked in cookies or brownies.

Oral administration of cannabis material leads to incomplete absorption. Therefore, the dose must be two or three times larger to achieve the same subjective effect as when it is smoked. Most of the drug is metabolized in the liver.

Short-Term Effects

The subjective effects of marijuana are almost always pleasant. "Getting high" on marijuana Cannabis intoxication is often accompanied by *temporal disintegration,* a condition in which people have trouble in retaining and organizing information, even over relatively short periods of time refers to a pervasive sense of well-being and happiness.

Long-Term Consequences

Withdrawal symptoms are unlikely to develop among occasional smokers of marijuana. People who have been exposed to continuous, high doses of THC may experience withdrawal symptoms, such as irritability, restlessness, and insomnia. Prolonged heavy use of marijuana may lead to certain types of performance deficits on neuropsychological tests, especially those involving sustained attention, learning, and decision making

12.9 Hallucinogens and Related Drugs

Drugs that are called **hallucinogens** cause people to experience hallucinations. Although many other types of drugs can lead to hallucinations at toxic levels, hallucinogens cause hallucinations at relatively low doses. There are many different types of hallucinogens, and they have very different neuro physiological effects.

Short-Term Effects

The effects of hallucinogenic drugs are difficult to study empirically because they are based primarily in subjective experience. They typically induce vivid, and occasionally spectacular, visual images. During the early phase of this drug experience, the images often take the form of colorful geometric patterns. The later phase is more likely to be filled with meaningful images of people, animals, and places. The images may change rapidly, and they sometimes follow an explosive pattern of movement. Although these hallucinatory experiences are usually pleasant, they are occasionally frightening.

Long-Term Consequences

The perceptual effects of hallucinogenic drugs almost always wear off after several hours. There are cases, however, in which these drugs have induced persistent psychotic behavior. Most experts interpret these examples as an indication that the drug experience can trigger the onset of psychosis in people who were already vulnerable to that type of disorder.

Check your progress

1. Name the psychomotor stimulant drugs
2. What is Hallucinogens drugs?

12.10 Causes

12.10.1 Social Factors

People who don't drink obviously won't develop alcoholism, and culture can influence that decision. Some cultures prohibit or actively discourage alcohol consumption. Many Muslims, for example, believe that drinking alcohol is sinful. Other religions encourage the use of small amounts of alcohol in religious ceremonies—such as Jewish people drinking wine at Passover seder. Several studies have examined social factors that predict substance use among adolescents. Initial experimentation with drugs is most likely to occur among those individuals who are rebellious and extroverted and whose parents and peers model or encourage use. The relative influence of parents and friends varies according to the gender and age of the adolescent as well as the drug in question. Parents can influence their children's drinking behaviors in many ways. They can serve as models for using drugs to cope with stressful circumstances. They may also help promote attitudes and expectations regarding the benefits of drug consumption,

12.10.2 Biological Factors

Genetics of Alcoholism

The strategy followed in an adoption study allows the investigator to separate relatively clearly the influence of genetic and environmental

factors. Participants in this type of study are individuals who meet two criteria: (1) They had a biological parent who was alcoholic, and (2) they were adopted from their biological parents at an early age and raised by adoptive parents. Investigators then locate these individuals when they have become adults and determine the frequency of alcoholism as a function of both biological and environmental background.

Neuroanatomy and Neurochemistry

All of the addicting drugs produce changes in the chemical processes by which messages are transmitted in the brain, including systems that involve catecholamines (for example, dopamine, norepinephrine, and serotonin), as well as the neuropeptides.

Dopamine and Reward Pathways

Scientists who study the biological basis of addiction have devoted a considerable amount of their attention to understanding the rewarding or reinforcing properties of drugs. People may become dependent on psychoactive drugs because they stimulate areas of the brain that are known as “reward pathways”. One primary circuit in this pathway is the medial forebrain bundle. The effects of alcohol on reward pathways in the brain are more complex and less clearly understood than the effects of many other drugs.

12.10.3 Psychological Factors

Expectations About Drug Effects

Placebo effects demonstrate that expectations are an important factor in any study of drug effects. This is certainly true in the case of alcohol. Expectations account for many effects that are sometimes assumed to be products of the drug itself. These expectations may constitute one of the primary reasons for continued and increasingly heavy consumption of alcoholic beverages. In fact, expectancy patterns can help predict drinking behaviors.

Integrated Systems

Alcoholism and other forms of addiction clearly result from an interaction among several types of systems. Various social, psychological, and biological factors influence the person's behavior at each stage in the cycle, from initial use of the drug through the eventual onset of tolerance and withdrawal. Furthermore, it appears that different influences are important at different stages of use. The process seems to progress in the following way. Initial experimentation with drugs is influenced by the environment—the person's family, peers, school, and neighborhood. Other people also influence the person's attitudes and expectations about the effects of drugs. Access to drugs, in addition to the patterns in which they are originally consumed, is determined, in part, by cultural factors.

12.11 Treatment

The treatment of alcoholism and other types of substance use disorders is an especially difficult task. Many people with substance use disorders do not acknowledge their difficulties, and only a relatively small number seek professional help. When they do enter treatment, it is typically with reluctance or on the insistence of friends, family members, or legal authorities.

12.11.1 Detoxification

Alcoholism and related forms of drug abuse are chronic conditions. Treatment is typically accomplished in a sequence of stages, beginning with a brief period of **detoxification**—the removal of a drug on which a person has become dependent—for three to six weeks. This process is often extremely difficult, as the person experiences marked symptoms of withdrawal and gradually adjusts to the absence of the drug.

12.11.2 Medications During Remission

Following the process of detoxification, treatment efforts are aimed at helping the person maintain a state of remission. The best outcomes are associated with stable, long-term abstinence from drinking. Several forms of medication are used to help the person

achieve this goal. Disulfiram (Antabuse) is a drug that can block the chemical breakdown of alcohol. It was introduced as a treatment for alcoholism in Europe in 1948 and is still used fairly extensively. If a person who is taking disulfiram consumes even a small amount of alcohol, he or she will become violently ill. The symptoms include nausea, vomiting, profuse sweating, and increased heart rate and respiration rate.

12.11.3 Self-Help Groups: Alcoholics Anonymous

One of the most widely accepted forms of treatment for alcoholism is Alcoholics Anonymous (AA). Organized in 1935, this self-help program is maintained by alcohol abusers for the sole purpose of helping other people who abuse alcohol become and remain sober.

12.11.4 Cognitive Behavior Therapy

Psychological approaches to substance use disorders have often focused on cognitive and behavioral responses that trigger episodes of drug abuse. In the case of alcoholism, heavy drinking has been viewed as a learned, maladaptive response that some people use to cope with difficult problems or to reduce anxiety.

Cognitive behavior therapy teaches people to identify and respond more appropriately to circumstances that regularly precipitate drug abuse.

12.11.5 Coping Skills Training

One element of cognitive behavior therapy involves training in the use of social skills, which might be used to resist pressures to drink heavily, includes problem-solving procedures, which can help the person both to identify situations that lead to heavy drinking and to formulate alternative courses of action.

12.12 Let's sum up

The *DSM-5* classifies substance related disorders in two major diagnostic categories, substance-induced disorders (repeated episodes of drug intoxication or development of a withdrawal syndrome), and substance use disorders (maladaptive use of a substance leading to

distress or impaired functioning). Physiological dependence involves changes in the body as the result of regular use of a substance, such as the development of tolerance and a withdrawal syndrome. Psychological dependence involves habitual use of a substance to meet a psychological need, either with or without physiological dependence.

Depressants are drugs that depress or slow down nervous system activity. They include alcohol, sedatives and minor tranquilizers, and opioids. Their effects include intoxication, impaired coordination, slurred speech, and impaired intellectual functioning. Chronic alcohol abuse is associated with health risks including Korsakoff's syndrome, cirrhosis of the liver, fetal alcohol syndrome, and other physical health problems epilepsy, among other uses. Like alcohol, they can impair driving ability and also can be dangerous in overdose situations, especially when use of barbiturates is combined with alcohol.

Opioids such as morphine and heroin are derived from the opium poppy. Others are synthesized. Opioids are used medically for relief of pain and are strongly addictive and can result in lethal overdoses. Stimulants increase activity in the central nervous system. Amphetamines and cocaine are stimulants that increase the availability of neurotransmitters in the brain, leading to heightened states of arousal and pleasurable feelings. High doses can produce psychotic reactions that mimic features of paranoid schizophrenia. Habitual cocaine use can lead to a variety of health problems, and an overdose can cause sudden death. Repeated use of nicotine, a mild stimulant found in tobacco, leads to physiological dependence.

Hallucinogens are drugs that distort sensory perceptions and can induce hallucinations. They include LSD, psilocybin, and mescaline. Other drugs with similar effects are cannabis (marijuana) and phencyclidine, a deliriant that can induce a state of mental confusion or delirium. Although hallucinogens may not lead to physiological dependence, psychological dependence may occur. Concerns are also raised about the potential for brain damage affecting learning and memory ability in heavier users of marijuana. Biological approaches to substance use disorders include detoxification; the use of drugs such as disulfiram, methadone, naltrexone, and antidepressants; and nicotine

replacement therapyResidential treatment approaches include hospitals and therapeutic residences. Nonprofessional support groups, such as Alcoholics Anonymous, promote abstinence within a supportive group setting.

12.13 Unit end Exercise

1. Write about the consequences of Alcoholism.
2. What is Detoxification?
3. How do self help groups helps the Alcoholic people?
4. Describe the social factors that influence the substance use?

12.14 Answers for check your progress

1. Amphetamine and Cocaine
2. Drugs that are called hallucinogens cause people to experience hallucinations.

12.15 Suggested Readings

1. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.
2. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.

UNIT 13

CAUSES AND RISK FACTORS FOR ABNORMAL BEHAVIOUR

Structure

13.1 INTRODUCTION

From early times, those who observed disordered behavior grappled with the question of its cause. Hippocrates, for example, had a type of disease model and suggested that an imbalance in the four bodily humors produced abnormal behavior, with each humor connected with certain kinds of behavior. To other observers, the cause was possession by demons or evil spirit. Later, bodily dysfunction was suggested as a cause. Each attempt at identifying a cause brought with it a theory, or model, of abnormal behavior. Today we are still puzzling over the causes of abnormal behavior, and speculation about causes continues to give rise to new models of abnormality. Since about 1900, several important schools of thought have developed elaborate models to explain the origins of abnormal behavior and to suggest how it might be treated.

13.2 Objectives

By the end of this unit you will be able to understand the causes for various mental disorders.

- Biological causes
- Psychological causes
- Socio cultural causes

13.3 Causes and Risk Factors for Abnormal Behavior

Central to the field of abnormal psychology are questions about what causes people to experience mental distress and to behave in a maladaptive manner. If we knew the causes for given disorders, we might be able to prevent conditions that lead to them and perhaps reverse those that maintain them. It is difficult to understand the abnormal behavior because human behavior is so complex. Even the simplest human behavior, such as speaking or writing a single word, is the product of thousands of prior events—the connections among which are not always clear. As a result, many investigators now prefer to speak of *risk factors* (variables correlated with an abnormal outcome) rather than of causes

13.4 Diathesis-Stress Models

A predisposition toward developing a disorder is termed a diathesis. It can derive from biological, psychological, or socio cultural causal factors. Many mental disorders are believed to develop when some kind of stressor operates on a person who has a diathesis or *vulnerability* for that disorder. Hence we will discuss what are commonly known as **diathesis-stress models** of abnormal behavior. To translate these terms into the types of causal factors described earlier, the diathesis is a relatively distal necessary or contributory cause, but it is generally not sufficient to cause the disorder. Instead, generally must be a more proximal undesirable event or situation (the stressor), which may also be contributory or necessary but is generally not sufficient by itself to cause the disorder except in someone with the diathesis.

In *additive model*, individuals who have a high level of a diathesis may need only a small amount of stress before a disorder develops, but those who have a very low level of a diathesis may need to experience a large amount of stress for a disorder to develop. In other words, the diathesis and the stress sum together, and when one is high the other can be low, and vice versa; thus, a person with no diathesis or a very low level of diathesis could still develop a disorder when faced with truly severe stress. In what is called an *interactive model*, some amount of diathesis must be present before stress will have any effect. Thus, in the interactive model, someone with no diathesis will never develop the disorder, no matter how much stress he or she experiences, whereas someone with the diathesis will show increasing likelihood of developing the disorder with increasing levels of stress.

More complex models are also possible because diatheses often exist on a continuum, ranging from zero to high levels, or exceeding his or her personal resources. Since the late 1980s, attention has been focused on the concept of **protective factors**, which are influences that modify a person's response to environmental stressors, making it less likely that the person will experience the adverse consequences of the stressors. Protective factors operate only to help resist against the effects of a risk factor rather than to provide any benefits to people without risk factors.

Protective factors are not necessarily positive experiences. Indeed, sometimes exposure to stressful experiences that are dealt with successfully can promote a sense of self-confidence or self-esteem and thereby serve as a protective factor; thus some stressors paradoxically promote coping. Protective factors most often, but not always, lead to **resilience**— the ability to adapt successfully to even very difficult circumstances. This discussion should make it very clear that diathesis. Stress models need to be considered in a broad framework of *multi causal developmental models*. Specifically, in the course of development a child may acquire a variety of cumulative risk factors that may interact in determining his or her risk for psychopathology. It is also important to note, however, to understand what is abnormal, one must always have a good understanding of normal human development at biological, psychological, and socio cultural levels of analysis. This has been the focus of the rapidly growing field of **developmental psychopathology**, which focuses on determining what is abnormal at any point in development by comparing and contrasting it with the normal and expected changes that occur in the course of development.

Check your progress

1. What is a necessary cause? A sufficient cause? A contributory cause?
2. What is a diathesis-stress model of abnormal behavior?

13.5 The Biological Viewpoint and Biological Causal Factors

Mental disorders are thus viewed as disorders of the central nervous system, the autonomic nervous system, and/or the endocrine system that are either inherited or caused by some pathological process. At one time, people who adopted this viewpoint hoped to find simple biological explanations. Today, however, most clinical psychologists and psychiatrists recognize that such explanations are rarely simple, and many also acknowledge that psychological and socio cultural causal factors play important roles as well. The disorders first recognized as having biological or organic components were those associated with

gross destruction of brain tissue. These disorders are neurological diseases—that is, they result from the disruption of brain functioning by physical or biochemical means and often involve psychological or behavioral aberrations. For example, damage to certain areas in the brain can cause memory loss, and damage to the left hemisphere that occurs during a stroke can cause depression. However, most mental disorders are not caused by only neurological damage.

We will focus here on four categories of biological factors that seem particularly relevant to the development of maladaptive behavior: (1) neurotransmitter and hormonal abnormalities in the brain or other parts of the central nervous system, (2) genetic vulnerabilities, (3) temperament, and (4) brain dysfunction and neural plasticity.

13.5.1 IMBALANCES OF NEUROTRANSMITTER SYSTEMS

The belief that imbalances in neurotransmitters in the brain can result in abnormal behavior is one of the basic tenets of the biological perspective today Sometimes psychological stress can bring on *neurotransmitter imbalances*. These imbalances can be created in a variety of ways.

There may be excessive production and release of the neurotransmitter substance into the synapses, causing a functional excess in levels of that neurotransmitter.

- There may be dysfunctions in the normal processes by which neurotransmitters, once released into the synapse, are deactivated.
- Finally, there may be problems with the receptors in the postsynaptic neuron, which may be either abnormally sensitive or abnormally insensitive.

Although over a hundred neurotransmitters have been discovered to date, five different kinds of neurotransmitters have been most extensively studied in relationship to psychopathology:
(1) norepinephrine, (2) dopamine, (3) serotonin,
(4) glutamate, and (5) gamma aminobutyric acid (known as
GABA.

Norepinephrine has been implicated as playing an important role in the emergency reactions our bodies show when we are exposed to an

acutely stressful or dangerous situation, as well as in attention, orientation, and basic motives. The functions of dopamine include pleasure and cognitive processing, and it has been implicated in schizophrenia. Serotonin has been found to have important effects on the way we think and process information from our environment as well as on behaviors and moods. GABA, which is strongly implicated in reducing anxiety as well as other emotional states characterized by high levels of arousal

13.5.2 HORMONAL IMBALANCES

Some forms of psychopathology have also been linked to *hormonal imbalances*. **Hormones** are chemical messengers secreted by a set of endocrine glands in our bodies. Each of the endocrine glands produces and releases its own set of hormones directly into our bloodstream. One particularly important set of interactions occurs in the **hypothalamic-pituitary-adrenal axis (HPA axis)**. Activation of this axis involves:

1. Messages in the form of corticotrophin-releasing hormone (CRH) travel from the hypothalamus to the pituitary.
2. In response to CRH, the pituitary releases adrenocorticotrophic hormone (ACTH), which stimulates the cortical part of the adrenal gland (located on top of the kidney) to produce epinephrine (adrenaline) and the stress hormone **cortisol**, which are released into general circulation. Cortisol mobilizes the body to deal with stress.

3. Cortisol in turn provides negative feedback to the hypothalamus and pituitary to decrease their release of CRH and ACTH, which in turn reduces the release of adrenaline and cortisol. This negative feedback system operates much as a thermostat does to regulate temperature.

13.5.3 Genetic Vulnerabilities

The biochemical processes described above are themselves affected by **genes**, which consist of very long molecules of DNA (deoxyribonucleic acid) and are present at various locations on chromosomes. **Chromosomes** are the chain-like structures within a cell

nucleus that contain the genes. Genes are the carriers of genetic information Research in developmental genetics has shown that abnormalities in the structure or number of the chromosomes can be associated with major defects or disorders. For example, Down syndrome is a type of mental retardation in which there is a trisomy (a set of three chromosomes instead of two) in chromosome 21. Here the extra chromosome is the primary cause of the disorder. More typically, however, personality traits and mental disorders are not affected by chromosomal abnormalities. Instead they are more often influenced either by abnormalities in some of the genes on the chromosomes or by naturally occurring variations of genes known as *polymorphisms*. Although you will often hear about discoveries that "the gene" for a particular disorder has been discovered, vulnerabilities to mental disorders are almost always **polygenic**, which means they are influenced by multiple genes

13.5.4 Temperament

Temperament refers to a child's reactivity and characteristic ways of self-regulation. When we say that babies differ in temperament, we mean that they show differences in their characteristic emotional and arousal responses to various stimuli and in their tendency to approach, withdraw, or attend to various situations. Our early temperament is thought to be the basis from which our personality develops. Starting at about 2 to 3 months of age, approximately five dimensions of temperament can be identified: fearfulness, irritability and frustration, positive affect, activity level, and attention persistence and effortful control, although some of these emerge later than others. These seem to be related to the three important dimensions of adult personality: (1) neuroticism or negative emotionality, (2) extraversion or positive emotionality, and (3) constraint temperament may also set the stage for the development of various forms of psychopathology later in life. For example, children who are fearful and hyper vigilant in many novel or unfamiliar situations have been labeled *behaviorally inhibited.*
This trait has a significant heritable component and, when it is stable, is a risk factor for the development of anxiety disorders later in childhood.

13.5.5 Brain Dysfunction and Neural Plasticity

As noted earlier, specific brain lesions with observable defects in brain tissue are rarely a primary cause of psychiatric disorders. However, advances in understanding how more subtle deficiencies of brain structure or function are implicated in many mental disorders have been increasing at a rapid pace in the past few decades. There is considerable *neural plasticity*—flexibility of the brain in making changes in organization and function in response to pre- and postnatal experiences, stress, diet, disease, drugs, maturation, and so forth. Existing neural circuits can be modified, or new neural circuits can be generated. The effects can be either beneficial or detrimental to the individual, depending on the circumstances.. This research on neural and behavioral plasticity, in combination with the work described earlier on genotype– environment correlations, makes it clear why developmental psychopathologists have been devoting increasing attention to a **developmental systems approach**.

This approach acknowledges not only that genetic activity influences neural activity, which in turn influences behavior, which in turn influences the environment, but also that these influences are bidirectional. Various aspects of our environment (physical, social, and cultural) also influence our behavior, which in turn affects our neural.activity, and this in turn can even influence genetic activity.

Check your Progress

3. what is hormone? 4. what is neural plasticity?

13.6 Psychological Causal Factors

We begin life with few built-in patterns and a great capacity to learn from experience. What we do learn from our experiences may help us face challenges resourcefully and may lead to resilience in the face of future stressors. Unfortunately, some of our experiences may be much less helpful in our later lives, and we may be deeply influenced by factors in early childhood over which we have no control. Exposure to multiple uncontrollable and unpredictable frightening events is likely to leave a person vulnerable to anxiety and negative affect, a central

problem in a number of mental disorders such as anxiety and depression. In this section we will examine the types of psychological factors that make people vulnerable to disorder or that may precipitate disorder. We will focus on four categories of psychological causal factors that can each have important detrimental effects on a child's socio emotional development: (1) early deprivation or trauma, (2) inadequate parenting styles, (3) marital discord and divorce, and (4) maladaptive peer relationships

13.6.1 Early Deprivation or Trauma

Children who do not have the resources that are typically supplied by parents or parental surrogates may be left with deep and sometimes irreversible psychological scars. Deprivation of such resources can occur in several forms. The most severe manifestations of deprivation are usually seen among abandoned or orphaned children, who may be either institutionalized or placed in a succession of unwholesome and inadequate foster homes. However, it can also occur in intact families where, for one reason or another, parents are unable (for instance, because of mental disorder) or unwilling to provide close and frequent human attention and nurturing. We can interpret the consequences of parental deprivation from several psychological viewpoints. Such deprivation might result in fixation at the oral stage of psychosexual development (Freud); it might interfere with the development of basic trust (Erikson); it might retard the attainment of needed skills because of a lack of available reinforcements (Skinner); or it might result in the child's acquiring dysfunctional schemas and self-schemas in which relationships are represented as unstable, untrustworthy, and without affection (Beck).

13.6.2 INSTITUTIONALIZATION

In some cases children are raised in an institution where, compared with an ordinary home, there is likely to be less warmth and physical contact; less intellectual, emotional, and social stimulation; and a lack of encouragement and help in positive learning. Many children institutionalized in infancy and early childhood show severe emotional, behavioral, and learning problems and are at risk for disturbed attachment relationships and psychopathology.

13.6.3 NEGLECT AND ABUSE IN THE HOME

Most infants subjected to parental deprivation are not separated from their parents but, rather, suffer from maltreatment at home. Outright parental abuse (physical or sexual or both) of children has been associated with many negative effects on their emotional, intellectual, and physical development, although some studies have suggested that, at least among infants, gross neglect may be worse than having an abusive relationship. Abused children often have a tendency to be overly aggressive (both verbally and physically), Abused and maltreated infants and toddlers are also quite likely to develop atypical patterns of attachment—most often a *disorganized* and *disoriented style of attachment.*

13.6.4 Inadequate Parenting Styles

Even in the absence of severe deprivation, neglect, or trauma, many kinds of deviations in parenting can have profound effects on a child’s subsequent ability to cope with life’s challenges and thus can create a child’s vulnerability to various forms of psychopathology. a parent–child relationship is always bidirectional: As in any continuing relationship, the behavior of each person affects the behavior of the other. Some children are easier to love than others; some parents are more sensitive than others to an infant’s needs

PARENTAL PSYCHOPATHOLOGY

In general, it has been found that parents who have various forms of psychopathology (including schizophrenia, depression, antisocial personality disorder, and alcohol abuse or dependence) tend to have one or more children who are at heightened risk for a wide range of developmental difficulties.

PARENTING STYLES: WARMTH AND CONTROL

Researchers have been interested in how parenting styles—including their disciplinary styles—affect children’s behavior over the course of development. A parenting style reflects an attitude and values that are expressed toward a child across a wide range of settings. Four types of parenting styles have been identified that seem to be related to different developmental outcomes for the children: (1) authoritative, (2) authoritarian, (3) permissive/indulgent, and (4) neglectful/uninvolved.

These styles vary in the degree of *parental warmth* (amount of support, encouragement, and affection versus shame, rejection, and hostility) and in the degree of *parental control.* Parental control includes both behavioral control (rewards and punishments) and psychological control (e.g., expression of approval vs disapproval, or guilt induction).

13.7 MARITAL DISCORD

Whatever the reasons for marital discord, when it is long-standing it is likely to be frustrating, hurtful, and generally damaging in its effects on both adults and their children. More severe cases of marital discord may expose children to one or more of the stressors we have already discussed: child abuse or neglect, the effects of living with a parent with a serious mental disorder, authoritarian or neglectful/ uninvolved parenting, and spouse abuse. But even less severe cases of marital discord also have negative effects on many children. For example, one study showed that children of parents with high levels of overt conflict showed a greater disposition to behave aggressively toward both their peers and their parents.

Effects of Divorce on Children

Divorce can have traumatic effects on children, too. Feelings of insecurity and rejection may be aggravated by conflicting loyalties and, sometimes, by the spoiling the children may receive while staying with one of the parents. Not surprisingly, some children do develop serious maladaptive responses. Temperamentally difficult children are likely to have a more difficult time adjusting. Delinquency and a wide range of other psychological problems such as anxiety and depression are much more frequent among children and adolescents from divorced.

Maladaptive Peer Relationships

Important peer relationships usually begin in the preschool years. Children at this stage are hardly masters of the fine points of human relationships or diplomacy. The child’s own immediate satisfaction tends to be the primary goal of any interaction, and there is only an uncertain recognition that cooperation and collaboration may bring even greater benefits. A substantial minority of children seem somehow ill equipped for the rigors and competition of the school years, often because of temperamental factors in the child or dysfunctional family

situations. A significant number of them withdraw from their peers and become loners. A significant number of others (especially males) adopt physically intimidating and aggressive lifestyles, often becoming schoolyard or neighborhood bullies. Being either a loner or a bully does not bode well for good mental health outcomes. In recent years a new form of particularly insidious bullying has emerged as an enormous problem in many countries. *Cyber bullying*, as it is called, includes sending offensive, harassing, or intimidating messages over the Internet, spreading ugly rumors on certain Internet sites, and spreading someone's very personal information. Some estimate that as many as one-third of teenagers who use the Internet engage in cyber bullying. The psychological consequences of cyber bullying on the victims can be very serious— including anxiety, school phobia, lower self-esteem, suicidal ideation, and occasional cases of suicide.

Check your Progress

5. How does parenting style affects child's mental health?
6. What is cyber bullying?

13.8 Socio cultural Causal Factors

Each socio cultural group fosters its own cultural patterns by systematically teaching its offspring, all its members tend to be somewhat alike. Children reared among headhunters tend to become headhunters; children reared in societies that do not sanction violence usually learn to settle their differences in nonviolent ways. The more uniform and thorough the education of the younger members of a group, the more alike they will become. There are many sources of pathogenic social influences. Some of these stem from socioeconomic factors. Others stem from socio cultural factors regarding role expectations and from the destructive forces of prejudice and discrimination.

Low Socioeconomic Status and Unemployment

In our society the lower the socioeconomic class has the higher the incidence of mental and physical disorders. The strength of this inverse correlation varies with different types of mental disorder. Thus lower

socioeconomic groups may show increased prevalence of mental and physical disorders due at least partly to increased stress on the people at risk. Other studies have examined the effects of unemployment on adults and children. Since the 1970s, there have been a number of severe economic recessions experienced worldwide, and significant rates of unemployment have accompanied each. Studies have repeatedly found unemployment— with its financial hardships, self-devaluation, and emotional distress—to be associated with emotional distress and enhanced vulnerability to psychopathology. Recent evidence suggests that it is the financial difficulties often resulting from unemployment that lead to the elevated levels of distress and mental disorders.

Prejudice and Discrimination in Race, Gender, and Ethnicity

Vast numbers of people in our society have been subjected to demoralizing stereotypes as well as to both overt and covert discrimination in areas such as employment, community, religion, and status. Prejudice against minority groups may also explain why these groups sometimes show increased prevalence of certain mental disorders such as depression. One possible reason for this is that perceived discrimination may serve as a stressor that threatens self-esteem, which in turn increases psychological distress.

Social Change and Uncertainty

The rate and pervasiveness of change today are different from anything our ancestors ever experienced. All aspects of our lives are affected—our education, our jobs, our families, our health, our leisure pursuits, our finances, and our beliefs and values. Constantly trying to keep up with the numerous adjustments demanded by these changes is a source of considerable stress. Simultaneously, we confront inevitable crises as the earth's consumable natural resources dwindle, as our environment becomes increasingly noxious with pollutants, and as global warming occurs. No longer people are confident that the future will be better than the past or that technology will solve all our problems. On the contrary, our attempts to cope with existing problems seem increasingly to create new problems that are as bad or worse. The resulting despair, demoralization, and sense of helplessness are well-

established predisposing conditions for abnormal reactions to stressful events.

13.9 Let's Sum Up

In considering the causes of abnormal behavior, it is important to distinguish among necessary, sufficient, and contributory causal factors, as well as between relatively distal causal factors and those that are more proximal.

This chapter discusses biological, psychological, and socio cultural viewpoints, each of which tends to emphasize the importance of causal factors of a characteristic type. Ultimately we strive for an integrative bio psychosocial viewpoint.

In examining biologically based vulnerabilities, we must consider abnormalities in neuro chemical and hormonal systems, genetic vulnerabilities, temperament, and brain dysfunction and neural plasticity.

Sources of psychologically determined vulnerability include early social deprivation or severe emotional trauma, inadequate parenting styles, marital discord and divorce, and maladaptive peer relationships.

The socio cultural viewpoint is concerned with the contribution of socio cultural variables to mental disorder. Although many serious mental disorders are fairly universal, the form that some disorders take and their prevalence vary widely among different cultures.

Low socioeconomic status and unemployment; being subjected to prejudice and discrimination in race, gender, and ethnicity; experiencing social change and uncertainty; and urban violence and homelessness are all associated with greater risk for various disorders.

13.10 Unit End Exercise

1. Define the terms protective factors and resilience. Give examples of each.
2. Explain how neurotransmitter and hormonal abnormalities might produce abnormal behavior.
3. What is temperament, and why is it important for the origins of abnormal behavior?

4. What is the typical range of effects that divorce and marital discord can have on children? What about effects on adults?
5. What are two different types of popular children and two different types of rejected children?
6. What effects do low SES and unemployment have on adults and children?

13.11 Answers for check your progress

1. A necessary cause is a condition that must exist for a disorder to occur.

2. A predisposition toward developing a disorder is termed a diathesis. It can derive from biological, psychological, or socio cultural causal factors. Many mental disorders are believed to, develop when some kind of stressor operates on a person who has a diathesis or *vulnerability* for that disorder.

3. Hormones are chemical messengers secreted by a set of endocrine glands in our bodies.

4 **N***eural plasticity* means flexibility of the brain in making changes in organization and function in response to pre- and postnatal experiences, stress, diet, disease, drugs, maturation, and so forth.

5. Parenting style affects child's behavior and cognitive structure in early childhood which laid the foundation to the personality development in adulthood.

6. Cyber bullying, as it is called, includes sending offensive, harassing, or intimidating messages over the Internet, spreading ugly rumors on certain Internet sites, and spreading someone's very personal information.

13.12 Suggested Readings

1. Butcher, J.N. (2014). Abnormal Psychology. New Delhi: Pearson Education.
2. Butcher, J.N., Hooley, J. M., Mineka, S &Dwivedi, C.B. (2017). Abnormal Psychology 16th ed. Noida: Pearson.
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UNIT 14

ADJUSTMENT DISORDER

Structure

14.1 INTRODUCTION

Nowadays it is very common to hear that, I am stressed. The word stress is used by the child as well as the old age people. You may wonder what they are saying about, what causes this stress. Our life events like unemployment, separation of loved ones, natural disasters, or brutal accidents triggers the stress level in our body. The coping skills varies depend upon the individuals. This maladaptive coping style creates stress.

14.2 Objectives

After studying this unit, you will be able to understand the following concepts

- Stress and stressors
- Reaction to stressful events

- Characteristics of adjustment disorder
- Types of adjustment disorders such as Acute stress disorder and
- Post traumatic stress disorder.

14.3 Meaning of Stress

The term *stress* refers to pressure or force placed on a body. In the physical world, tons of rock that crash to the ground in a landslide, for example, cause stress on impact, forming indentations or craters when they land. In psychology, we use the term stress to refer to pressures or demands placed on organisms to adapt or adjust. A stressor is a source of stress. Stressors (or stresses) include psychological factors, such as examinations in school and problems in social relationships, and life changes, such as the death of a loved one, divorce, or a job termination. Stress is implicated in a wide range of physical and psychological problems. We begin our study of the effects of stress by discussing relationships between stress and health. We then examine stress-related psychological disorders that involve maladaptive reactions to stress.

14.4 The General Adaptation Syndrome

Stress researcher Hans Selye (1976) coined the term general adaptation syndrome (GAS) to describe a common biological response pattern to prolonged or excessive stress. Selye pointed out that our bodies respond similarly to many kinds of unpleasant stressors, whether the source of stress is an invasion of microscopic disease organisms, a divorce, or the aftermath of a flood.

The GAS consists of three stages: the alarm reaction, the resistance stage, and the exhaustion stage. Perception of an immediate stressor (e.g., a car that swerves in front of you on the highway) triggers the alarm reaction. The alarm reaction mobilizes the body to prepare for challenge or stress.

In 1929, Harvard University physiologist Walter Cannon termed this response pattern the fight-or-flight reaction. During the alarm reaction, the adrenal glands, controlled by the pituitary gland in the brain, pump out cortical steroids and stress hormones that help mobilize

the body's defenses. The fight-or-flight reaction most probably helped our early ancestors cope with the many perils they faced. The reaction may have been provoked by the sight of a predator or by a rustling sound in the undergrowth. The fight-or-flight reaction most probably helped our early ancestors cope with the many perils they faced. The reaction may have been provoked by the sight of a predator or by a rustling sound in the undergrowth. (e.g., release of stress hormones) remain at high levels, but not quite as high as during the alarm reaction.

During the resistance stage, the body tries to renew spent energy and repair damage. But when stressors continue or new ones appear, we may progress to the final stage of the GAS: the exhaustion stage. Although there are individual differences in capacity to resist stress, all of us will eventually exhaust our bodily resources. The exhaustion stage is characterized by dominance of the parasympathetic branch of the ANS.

Check your Progress

1. What is stress?
2. Describe the stages of General Adaptive syndrome

14.5 ADJUSTMENT DISORDER

An adjustment disorder is a maladaptive reaction to a distressing life event or stressor that develops within 3 months of the onset of the stressor. The stressful event may be either a traumatic experience, such as a natural disaster or a motor vehicle accident with serious injury, or a non traumatic life event, such as the breakup of a romantic relationship or starting college.

According to the *DSM*, the maladaptive reaction is characterized by significant impairment in social, occupational, or other important area of functioning, such as academic work, or by marked emotional distress exceeding what would normally be expected in coping with the stressor. Prevalence estimates of the rates of the disorder in the population vary widely. However, the disorder is common among people seeking outpatient mental health care, with estimates indicating that between 5% and 20% of people receiving outpatient mental health services present with a diagnosis of adjustment disorder.

Characteristics of Adjustment Disorder

Our emotional reaction exceeds an expected response, or our ability to function is impaired (e.g., avoidance of social interactions, difficulty getting out of bed, or falling behind in schoolwork), then a diagnosis of adjustment disorder may be indicated. Thus, if you are having trouble concentrating on your schoolwork following the breakup of a romantic relationship and your grades are slipping, you may have an adjustment disorder. There are several specific types of adjustment disorders that vary in terms of the type of maladaptive reaction.

For the diagnosis of an adjustment disorder to apply, the stress related reaction must not be sufficient to meet the diagnostic criteria for other or posttraumatic stress disorder), or anxiety or mood disorders or mood disorder. The maladaptive reaction may be resolved if the stressor is removed or the individual learns to cope with it. If the adjustment disorder lasts for more than six months after the stressor (or its consequences) has been removed, the diagnosis may be changed. Although the *DSM* system distinguishes adjustment disorder from other clinical syndromes, it may be difficult to identify distinguishing features of adjustment disorders that are distinct from other disorders, such as depression, such as traumatic stress disorders (acute stress disorder).

Traumatic Stress Disorders

In adjustment disorders, people may have difficulty adjusting to stressful life events such as business or marital problems, termination of a romantic relationship, or death of a loved one. But with traumatic stress disorders, the focus shifts to how people cope with disasters and other traumatic experiences. Exposure to trauma can tax anyone’s ability to adjust. For some people, traumatic experiences lead to the development of traumatic stress disorders, which are characterized by maladaptive patterns of behavior in response to trauma that involve marked personal distress or significant impairment of functioning.

Here we focus on the two major types of traumatic stress disorders, *acute stress disorder* and *posttraumatic stress disorder*.

14.5.1 Acute Stress Disorder

In acute stress disorder, the person shows a maladaptive pattern of behavior for a period of three days to one month following exposure to a traumatic event. The traumatic event may involve exposure to either actual or threatened death, a serious accident, or a sexual violation. The person with acute stress disorder may have been directly exposed to the trauma, witnessed other people experiencing the trauma, or learned about a violent or accidental traumatic event experienced by a close friend or family member. People with acute stress disorder may feel they are "in a daze" or that the world seems like a dreamlike or unreal place. The symptoms or features of acute stress disorder vary and may include disturbing, intrusive memories or dreams about the trauma;
re experiencing the trauma in the form of flashbacks; feelings of unreality or detachment ("dissociation") from one's surroundings or from oneself; avoidance of external reminders of the trauma (such as places or people associated with the trauma); problems sleeping; and development of irritable or aggressive behavior or an exaggerated startle response to sudden noises.

14.5.2 Posttraumatic Stress Disorder

Posttraumatic stress disorder is a prolonged maladaptive reaction that lasts longer than one month after the traumatic experience. PTSD presents with a similar symptom profile as acute stress disorder, but may persist for months, years, or even decades, and may not develop until many months or even years after the traumatic event. Many people with acute stress disorder, but certainly not all, go on to develop PTSD. Researchers find both types of traumatic stress disorders in soldiers exposed to combat and among rape survivors, victims of serious motor vehicle and other accidents, and people who have witnessed the destruction of their homes and communities by natural disasters, such as floods, earthquakes, or tornadoes, or technological disasters, such as railroad or airplane crashes.

1. What is Adjustment Disorder?
2. What is Acute stress disorder?
3. What is PTSD?

14.6 Causes

Some vulnerability factors relate to the traumatic event itself, such as the degree of exposure to the trauma, whereas others relate to the person or the social environment. The more direct the exposure to the trauma, the greater the person's likelihood of developing PTSD. Another factor relating to the likelihood of developing PTSD is gender. Although men more often have traumatic experiences, women are more likely to develop PTSD, about twice as likely. However, women's greater vulnerability to PTSD may have more to do with their greater incidence of sexual victimization and with their younger ages at the time of trauma than with gender itself. Other vulnerability factors relate to personal and biological factors. Genetic factors involved in regulating the body's response to stress appear to play a part in determining a person's susceptibility to PTSD in the wake of trauma.

Recently, investigators reported that the *amygdala,* a small structure in the brain's limbic system that triggers the body's fear response, was smaller in a group of combat veterans with PTSD than in combat veterans without PTSD. Other factors linked to increased vulnerability to PTSD include a history of childhood sexual abuse, lack of social support, and limited coping skills. Personality factors such as lower levels of self-efficacy and higher levels of hostility are also linked to increased risk of PTSD. People who experience unusual symptoms during or immediately after the trauma, such as feeling that things are not real or feeling as though one were watching oneself in a movie as the events unfold, stand a greater risk of developing PTSD.

14.7 Treatment Approaches

Cognitive-behavioral therapy has produced impressive results in the treatment of PTSD. The basic treatment component is repeated exposure to cues and emotions associated with the trauma. In cognitive-behavioral therapy, the person gradually re experiences the anxiety associated with the traumatic event in a safe setting, thereby allowing extinction to take its course. The PTSD patient may be encouraged to repeatedly talk about the traumatic experience, re experience the emotional aspects of the

trauma in imagination, view related slides or films, or visit the scene of the traumatic event. Training in stress management skills, such as self-relaxation, can also improve the client's ability to cope with troubling symptoms of PTSD, such as heightened arousal and the desire to run away from trauma-related stimuli. Training in anger management skills may also be helpful, especially for combat veterans with PTSD. Treatment with antidepressant drugs, such as *sertraline* (Zoloft) or *paroxetine* (Paxil), may help reduce the anxiety components of PTSD.

14.8 Let's Sum Up

Exposure to stress, especially traumatic stress like that experienced by many thousands of people stress can have profound effects on our physical and emotional health. Psychologists who study interrelationships between psychological factors, including stress, and physical health are called health Psychologists. The term *stress* refers to pressure or force placed on a body. The general adaptation syndrome, (1) the alarm reaction, in which the body mobilizes its resources to confront a stressor; (2) the resistance stage, in which bodily arousal remains high but the body attempts to adapt to continued stressful demands; and (3) the exhaustion stage, in which bodily resources b These factors include effective coping styles, self-efficacy expectancies, psychological hardiness, optimism, and social support. Adjustment disorders are maladaptive reactions to identified stressors.

Adjustment disorders are characterized by emotional reactions that are greater than normally expected given the circumstances The two types of traumatic stress disorders are acute stress disorder and posttraumatic stress disorder. Both involve maladaptive reactions to traumatic stressors. Acute stress disorder occurs in the days and weeks following exposure to the traumatic event. Posttraumatic stress disorder

persists for months, years, or even decades after the traumatic experience and may not begin until months or years after the event.

14.9 Unit End Exercise

1. Explain Adjustment Disorders and its types.

2. What is PTSD? Explain causes for PTSD?

3. Write about the various treatment approaches for adjustment disorders.

14.10 Answers for Check your Progress

1. The term stress refers to pressures or demands placed on organisms to adapt or adjust.

2. The general adaptation syndrome, which is characterized by three stages: (1) the alarm reaction, in which the body mobilizes its resources to confront a stressor; (2) the resistance stage, in which bodily arousal remains high but the body attempts to adapt to continued stressful demands; and (3) the exhaustion stage, in which bodily resources become dangerously depleted in the face of persistent and intense stress, and stress-related disorders, or diseases of adaptation, may develop.

3. Adjustment disorders are maladaptive reactions to identified stressors. Adjustment disorders are characterized by emotional reactions that are greater than normally expected given the circumstances or by evidence of significant impairment in functioning.

4. Acute stress disorder occurs in the days and weeks following exposure to the traumatic event.

5. Posttraumatic stress disorder is a prolonged maladaptive reaction that lasts longer than one month after the traumatic experience. PTSD

presents with a similar symptom profile as acute stress disorder, but may persist for months, years, or even decades,

14.11 Suggested Readings

1. Butcher, J.N. (2014). Abnormal Psychology. New Delhi: Pearson Education.
2. Butcher, J.N., Hooley, J. M., Mineka, S &Dwivedi, C.B. (2017). Abnormal Psychology 16th ed. Noida: Pearson.
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